A PSYCHODYNAMIC APPROACH TO SHORT-TERM COUPLES THERAPY IN CLINICAL SOCIAL WORK

Some aspects of the Combined Conjoint-Concurrent Technique

by

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ABSTRACT

In this dissertation, the writer explores and supports the validity of clinical social work practitioners applying planned therapeutic intervention procedures to couples who are in distress.

Written in two parts, this paper is esentially a review of selected literature on the efficacy of social work psychotherapy with couples.

Couple therapy, which deals with the two individuals per se and not merely with their interaction, enhances the treatment of both partners. Several intervention strategies are noted by the writer, all of which attempt to alter both individual dynamics and that of the couples relationship.

The writer has chosen a "fusion model" comprising of the intra and inter-personal intervention strategies. The therapeutic format of choice proposed by the writer favours a time-limited psychodynamic approach which operates through the medium of a combined concurrent-conjoint technique.

In support of the above, the dissertation is introduced by an attempt to trace the historical development of clinical social work as a profession. In so doing, claim is laid to the legitimate clinical practice with couples, by social work psychotherapists. Flowing from this, clinical social work practice is conceptualised, defined and formulated.

The writer systematically contrasts and compares the major current theoretical approaches in couples therapy, emphasising the psychodynamic model as the preferred method of intervention.

The writer then looks to established models of psychodynamic

couples therapy, highlighting their principle concepts and assessment procedures. What emerges is the necessity for concentration on intra-personal dynamics as derived from the client's family of origin, and which is then projected on to the other partner, thus aggravating discord from within the dyadic system.

Issues of transference and counter-transference are discussed. The therapist's willingness to risk him/herself in the context of the helping relationship is examined.

At this point, the writer presents an overview of four alternative techniques which serve as a means to therapeutic action in couples therapy. The practical application of each is discussed, as their positive and negative aspects influence the therapist's choice of method. Of these, the writer chooses a combination of two alternatives which the literature describes as the "combined simple technique".

Part One closes with practical suggestions for commencing treatment utilizing the psychodynamic approach and combined simple technique. The reader, too, is reminded of the importance of the clinical home visit as an adjunct to therapy.

Part Two of the dissertation is concerned with the structure of therapeutic intervention in couples therapy. A time-limited, dynamic format for this purpose is proposed. Selection of clients for this form of treatment is also discussed.

In order to demonstrate the effectiveness of short term treatment, the writer draws on authors such as Parad, Segraves, and Klier. Their plea for the scientific evaluation of social work intervention is noted and advocated by the writer. A criticism of the writer's proposed intervention model is also included.

The writer concludes by indicating the beneficial value inherent in the psychodynamic approach to couples therapy.

INTRODUCTION

The Nature of Clinical Social Work

In order to appreciate the writer's purpose in presenting the rationale which constitutes the body of this dissertation, it is important to the reader to have an understanding of the events and developments that shaped the concept of clinical social work. The writer feels that a historical introduction to this "new specialism in social work practice" is extremely important. Any attempt to argue the case for clinical social workers becoming involved in the therapy and treatment of individuals, let alone couples, will need to be explored from both an historical and a theoretical point of view. Once convinced, the reader may accept the validity of clinical social workers doing therapy and treating couples in distress.

> "Historically, social work has been dedicated to the enhancement of man's social functioning by an approach focussed on both the individual and his social environment." [1]
>
> Taber and Vattano (1970)[1]

In order to reach a better understanding of the historical development of clinical social work as a specialisation of generic social work, it can be argued that what is primarily needed is to see the unfolding of the relationship between generic social work and the great impact the psychoanalytic movement had on social work practitioners during the early twenties. What is highlighted is the beginnings of clinical social work and its effect on contemporary practice.

As the content of this dissertation concerns psychodynamic therapy with couples in a committed relationship, the writer, throughout this paper, advocates this theme as a preferred approach to working with couples in therapy.

It is the writer's conviction that there is no substitute for a psychodynamic understanding as the basic framework upon which any variations in technique can and must rest. This presupposes that the therapist possesses a sound knowledge of psychodynamic principles, an understanding of the generic (historical) roots of the client's problems, and an ability to evaluate the factors involved in the presenting psychopathology or disturbance in the relationship.

It would follow then, that the more one knows about psychodynamic treatment, the better one is able to make a rational decision about which psychotherapeutic technique or even combination of techniques is most likely to be the most helpful to any particular client or couple system.

A brief overview of the major techniques used by most therapists is offered. The writer has chosen out of these, the combined approach to couples therapy as the most viable alternative when using the psychodynamic framework.

The concept of joint psychotherapy in the treatment of couples' discord as interpreted by the writer, enhances the clinical social worker's approach professionally and competently. The clinician's ability to think in dynamic, generic, economic, structural and adaptive terms, is central to the sound evaluation and therapeutic treatment of couples discord.

PART ONE

Chapter 1

1.1 Social Work and Psychoanalytic Theory

Borenzweig (1971)[2] notes that during the years 1896 - 1916, the beginning of a 'socially progressive era" was dawning in the United States.

Industrialisation had enriched the country beyond any foreseen expectations of the industrialists and economists. Of note, also, was the beginning of the struggle for the emancipation of women. Women were seen as becoming more active in public affairs. In fact, many of the social work reformers and pioneers who began building the social work profession at that time in the United States, were middle and upper-class women. Borensweig [1971] notes further that the challenge and changes in the social order plus rapid industrial growth and a certain "clamour for reform", were the issues which began to pull social work out of its charitable mould into a more professional direction. What finally catapulted social work from its early beginnings to a new professional status, was the growing acceptance of psychoanalysis after World War 1. Borensweig [1971] maintains that this process was instrumental in changing the focus of social work practice, to where it no longer dealt exclusively with the problems of the poor.

The gradual move away from the traditional practice of working with the poor in many ways strengthened the development of the profession towards a clinical approach,

where the individual became the focus of more critical attention. The writer would argue that this was a point of departure for a more clinical approach in the decades to follow.

Borenzweig [1971] gives the reader a vivid description of how the "caring visitors" and caseworkers enthusiastically supported the use of psychoanalytic concepts in the treatment of soldiers suffering from 'neurasthenia' during World War 1. Thus the growing alliance with the fledgling science of psychoanalysis benefited and greatly enriched the practice of casework.

1.1.1 A Brief overview of the Psychoanalytic Movement in Social Work

Psychoanalysis became a turning point in traditional psychiatry as well as fuelling ideas about 'clinical' social work. The emergence of Freudian doctrines, the emancipation of women, the impact of psychoanalytic theories on the medical profession and the 'informed public', soon exercised a great influence on social work practice. There emerged a new scientific method of improving the 'mental welfare' of individuals and, later, families.

This impact on the social work profession was so vast and lasting, that Lindeman (1926)[3] noted that "a social work agency would not dare to make an appeal to any one of the large financial foundations without including somewhere in their budget, provision for the financing for individual mental hygiene programmes, even if family work was that agency's goal". Lindeman (1926) also takes note of a growing advocacy of 'psychiatric social work' as the latest technique within the profession.

This rapid evolution disturbed some of the social work

writers, educators and philosophers of the time. Their fear was that the fast-growing obsession with perfecting techniques of treatment using psychoanalytic concepts, had transformed the social worker's role by getting beyond more charitable acts, and working exclusively with the poor. Mackey (1964)[4] sums up the situation by pointing out the fact that the practice of social work no longer dealt with lower income families.

It was becoming ever apparent that privacy was a pre-requisite for working with people. Traditionally the social worker had never been assured of 'privacy' when paying a home visit in the early years of their work. Their primary task was to help the family toward economic self-sufficiency. Taking this into consideration, and the philosophy of helping destitute people at that time, there was no real need for the social worker to delve into the intrapsychic life of people or families.

There was therefore, a change of direction: from helping the family, to helping the individual client through exploration of intrapsychic dynamics, and social workers needed privacy to conduct their interviews.

MacKey (1964) points our that another feature that encouraged the use of the office visit, as opposed to the home visit, was that of motivation for help. He notes that for years social workers had been delivering a service where the more accepted norms of society were 'preached' to the community. It made sense somehow, to extend help to the poor and even if they were not asking for it, they were receiving it. The traditional orientation towards helping began to change. The process of professionalisation was well on the way. Social workers began asking themselves whether they could help people, even if people did not want to be helped.

Influenced by analytical thinking about motivation, as well as the principle concept of self-help (now central to social work practice) and that of self determination, the social work practitioner tended to expect clients to come to them if they wanted help. It now seemed that there was a need for social work services within the professional atmosphere of the agency. The effort made by the client (as they were now called) to come to the intake interview, was a test of the client's motivation to make use of the social worker's help.

In essence, what is being pointed out is that historically. the time had come for social workers to move from "forced volunteer relief work" to the more glamorous and challenging positions in the field of mental hygiene and related disciplines - the beginnings of clinical social work practice had been made.

This 'evolution of professional method' and the transition from influencing the client system in the home to office treatments, continues to the present.

The drifting apart of generic and clinical social work is evident as the clinical social work practitioner becomes increasingly identified with the more specialist human intervention strategies, methods and techniques applied in helping clients who are experiencing distress with their emotional problems of living.

1.2 Conceptualizing Clinical Social Work Practice

In trying to conceptualize the specialism of clinical social work, it is important to briefly examine the knowledge base of clinical social work first.

Goldstein (1980)[5] notes that what is probably needed in respect of a knowledge base, is a broad definition of

clinical social work. We find that upon close scrutiny, the core knowledge of clinical social work is not all that different from that of generic social work practice. The essence of the "overlap" is that no matter how clinical we become in social work, we still see an essential embodiment of a philosophy centered around helping people who are in transaction and interaction with other people and their environment, in a way that does justice to the client and his system.

The clinical practitioner in social work can perform several roles in this way and quite flexibly keep the client's situation, rather than a "favourite treatment method or technique," at the forefront of his or her concern. The same worker can be counsellor, therapist, enabler, systems negotiator, advocate and mediator, to suggest a few adaptations or possible roles. Interventions remain adjusted to the particular needs of the client as has always been practiced.

The word "clinical" might conjure up in one's mind the idea of sickness, pathology and healers in white coats, but, in the writer's opinion, clinical social work has moved beyond these concepts and deals with clients in a particular way, idiosyncratic to social work philosophy, treatment and method. Nevertheless, having indicated the above, a definition of clinical social work in terms of its evolutionary process, should be introduced at this point.

1.3 Perspectives on the Formulation of a definition of Clinical Social Work.

Strean (1978)[6] notes that as recently as a decade ago, the

National Association of Social Workers in the United States issued a register of clinical social workers for the first time.

The National Association of Social Workers (N.A.S.W.1983) defined a clinical social worker as one who is "by education and experience, professionally qualified at the autonomous practice level to provide direct, diagnostic, preventative and treatment-oriented services to individuals, families and groups where functioning is threatened or affected by social and psychological stress or health impairment". The register also offers the following:

> "Clinical social work is practiced within a private office or under the auspices of public, voluntary or proprietary agencies and institutions addressing familial, economic, health, recreational, religious, penal, judicial and educational concerns. Within the practice setting, the client's problem is identified, a plan of intervention is designed and agreed upon with the client. The plan is supported by securing historical facts and clues to the latent forces within the individual's personality. Individual strengths in conjunction with community resources are activated and utilized to implement the treatment plan."
>
> National Association of Social Workers (1983)

The writer feels that social work itself is difficult to define. This is in stark contrast, perhaps, to other professions. Strean (1978)succinctly defines clinical social work simply as "psychotherapy plus".

Eldridge (1983)[7], defines clinical social work therapy as "face to face interviews with clients to provide direct diagnostic, preventive and treatment services to individuals, families and groups where functioning is threatened or affected by social and or psychological stress. It addresses itself to the internal life of the client, seeking to modify maladaptive defences and increase ego strengths and includes concern for the client's interactions and transactions within his social orbit."

Finally, in 1983, the American National Association of Social Workers put out the following legal definition of clinical social work.

> "Clinical social work is thus defined as the professional application of social work practice, theories and methods in the treatment of mental and emotional conditions and the maintenance and enhancement of psychological functioning of individual families and small groups. Clinical social work embraces treatment directed to inter-personal interactions, intra-psychic dynamics, as well as life support and management issues. The principle of person-in-situtations is central to all clinical social work understanding and action. The process of clinical work is undertaken within the objectives of social work and the principles contained in the code of ethics for the social work profession. Clinical Social Work services include assessment, diagnosis, psycho-therapy and a range of other treatment interventions.
>
> Clinical social work services are designed to:
>
> (a) alleviate psychopathology through the modification of dysfunctional behaviour and/or symptom removal,
>
> (b) modify psycho-social conditions with respect to behaviour, emotions and thinking as these relate to their intrapersonal and interpersonal processes and

(c) assist patients to maintain or improve life situations threatened or affected by social and psychological stress or ill-health.

Clinical social work practice refers specifically to , but is not limited by, one or more of the following:

(a) assessment and diagnosis,

(b) psychotherapy and a range of the treatment interventions,

(c) consultations with and services for persons collateral to the primary client,

(d) consultation to other treatment service providers,

(e) collaboration with other treatment services providers,

(f) co-ordination of planning for services delivery".

(National Association of Social Workers 1983).[8]

1.4 At this point it is important to establish whether couples therapy is indeed a function of clinical social work practice. In the following chapter this issue is briefly discussed. An overview of the major current approaches, available to clinicians, in couples therapy is also presented.

Chapter 2

2.1 Clinical Practice of Couples Therapy

Marital Therapy is defined as "any therapeutic intervention technique which has as its major focus the alteration of the marital dyad". Olsen (1970)[9]

Marital therapy is defined as the application of any planned therapeutic techniques within the context of individual and/or conjoint and/or group modalities to modify maladaptive interactions and transactions of couples in a committed sexual relationship.

Herman (1982)[10]

Of note, is the concept that couples who have not entered into a legal contract of marriage may also enjoy a committed relationship as defined by Herman (1982). As such, reference made to couples therapy in the dissertation operationally extends to include "any couple, married or unmarried who have a committed sexual relationship". (This is discussed further in this chapter).

The writer feels that perhaps the goal of couples therapy can largely be seen as assisting a couple to 'better understand' their specific problematic interaction, and attempt to find ways in which their needs can be mutually satisfied, so that each partner may grow and develop in the relationship and allow the other to do the same.

Accepting that this is the goal in marital/couple therapy, then the elaborate statement mentioned earlier in respect of the goals of clinical social work must, by way of definition, dove-tail with the aims of marital therapy.

2.2 Major Current Theoretical Approaches in Couples Therapy; A Brief Synopsis.

As previously stated in the introduction to this dissertation, marital therapy is not an all-embracing theory about people who are legally married. People do not have to be related in the legal interpretation of the concept in order to benefit from counselling input. A more accurate term could be 'couples counselling' or 'couples therapy'.

There are at least three types of theoretical approaches in current thinking as regards basic treatment. Chasin and Grunebaum (1980)[11] note that there are those that explain the couples predicament from an (i) historic perspective, those that describe the couple's behaviour from an (ii) interactional perspective and (iii) those that indicate the quality of the couples relationship from an experimental perspective.

Segraves (1982)[12], sees the above approaches as being represented by (i) Psycholanalytic theory, (ii) General Systems Theory and (iii) Behavioural therapy.

The writer feels that couples therapy should be practiced within a body of knowledge as noted by Segraves. Segraves emphasises this by stating that "there is a danger in not remaining within a chosen theoretical boundary".

Each of these theories offers a format for therapeutic intervention. Segraves notes that couples therapy models derived from psychoanalytic theory, provide the clinician with a framework to understand the contribution of individual past experiences to the "genesis of dyadic discord".

As noted by Segraves, many experienced clinicians have evolved treatment models from personal trial and error.

In many cases these clinicians freely borrow assumptions and techniques from various theoretical camps without taking full cognisance of this practice.

It may be said that many of these clinicians are gifted and effective therapists, but they do not record their observations or even acknowledge the basic principles underlying their treatment strategy and techniques. The result is usually expert clinical wisdom with poor or faulty conceptualised theoretical procedure and/or assumptions in and around their "successes".

This, it may be argued, might have a distorted or minimal impact on those trying to adopt a particular style. It is important to the writer that therapists realise and document their particular adaptations of the couple therapy model they use. This could be seen a 'preserving' the real value and impact of their work. The argument for an explicit theoretical system for the conduct of couple-counselling or therapy is important in the writer's opinion because the therapy can be readily examined or criticised in a particular fashion. [This is to be discussed in greater depth in Chapter 5 (5.1)]

Walsh (1983)[13], describes the practice of couples therapy and the "larger" family therapy concepts as being grounded in a set of basic assumptions about the nature and interplay of individuals and families. The assessment and treatment of psycho-pathology and dysfunction in these systems is guided by principles or theoretical assumptions about the structure and functioning of these systems.

Such a system can be seen as one where the individual, as interrelated with another, or others, has a specific effect on his/her partner. This in turn has a reciprocal effect on the first individual, much like a circular chain of influence. The pattern is then perpetuated.

Walsh further notes that in the field of marital/couples therapy, writers have developed approaches that give emphasis to dynamics, structural patterns and communication processes. These writers tend to differ conceptually in their views of how symptoms occur and of how change takes place. Care should be taken when attempting to categorise a rapidly evolving field of theoretical practices. At the same time, it is important to survey the field in order to identify and distinguish the major models of marital therapy available to clinicians (in their intended original format).

2.3 A Systematic Review of the Major Approaches in Marital/Couples Therapy

Olson (1970)[14], presents a conceptual scheme for the description of the various approaches used in marital and family therapy. In tabular form they appear as follows:

TABLE 1 THERAPEUTIC INTERVENTION APPROACHES
2.1

SYSTEM FRAMEWORK	PRIMARY THERAPEUTIC UNIT	MAJOR THERAPEUTIC FOCUS	PRIMARY THERAPEUTIC GOAL
Intrapersonal	Individual	Intra-psychic Primary; Intrapersonal, Secondary	Improvement & Growth of Self
Inter-personal	Related individuals seen separately by same therapist or by collaborating therapists.	Interpersonal Primary Intrapsychic, Secondary	Improvement of a Relationship.
Quasi-interactional	Individual	Interactional Skill	Improvement and alteration in modes of interaction
Interactional	Ad-hoc Group of unrelated or related individuals.	Group Process, Primary intra-psychic, secondary.	Improvement of self & relationship with others
Transactional	Natural Group seen together	Marital and Family system	Improvement of Family inter-relations.

SOURCE: D.Olsen, Marital and Family Therapy: Integrative Review and Critique in Journal of Marriage and the Family, vol 32, No 1, November, 1970: p 506.

In Table 2, Olsen presents a sytematic analysis of the range of therapeutic approaches used in marital and family therapy. These approaches are categorised according to the framework emphasised and the treatment unit used. The "empty cells" in the table indicated either that the particular combination or a therapeutic approach cannot be achieved (at present) or that it has not been formally documented to date.

TABLE 2 ANALYSIS OF THERAPEUTIC APPROACHES AND THEIR 2.2 THERAPEUTIC TARGET.

Systems Framework	Individual	Parent-child Dyad	Marital Dyad	Family
Intrapersonal	Individual Psychotherapy			
Interpersonal		Collaborative Parent-child Therapy	Collaborative marital therapy	
		Concurrent Parent Child therapy	Concurrent marital therapy	
Quasi-interactional		Filial therapy	Conjugal Therapy	
Interactional	Group Psychotherapy	Parental Group Therapy	Marital Group Therapy	Multiple Group Therapy
Transctional		Conjoint parent-child therapy	Conjoint Marital therapy	Conjoint Family Therapy
				Multiple Impact Therapy
				Kin network Therapy.

SOURCE: D. Olsen, Marital and Family Therapy : Integrative Review and Critique in Journal of Marriage and the Family, vol 32, No 1, November, 1970: p 507.

The author notes too, that the five frameworks as laid out in these tables, all represent a rather distinct approach from each other. However, these are not pure types and always have some overlap with each other.

Each of the system frameworks and the therapeutic approaches representing each framework is now briefly described as it relates specifically to the couple system (Table 1)

2.3.1 The intra-personal system: This framework contains approaches which includes only one person and focuses on the conflicts and anxieties of the client. Inter-personal relationships are considered as being of secondary importance. Within this framework, the primary goal is to facilitate the improvement and growth of the client. This framework is perhaps best illustrated by most types of individual psychotherapy.

2.3.2 The inter-personal system: This system framework primarily focuses on the relationship between two particular people who are involved in a committed relationship with each other. The couple are not necessarily seen together in treatment. They are either seen individually, by two different therapists, who collaborate (i.e. collaborative therapy), or they are seen individually but by the same therapist concurrently, ie concurrent couple therapy.

The major focus of the treatment is on the inter-personal relationship, but secondary attention is also given to the intra-psychic material. The goal of the treatment is primarily improvement of the relationship. The therapist may not directly observe the dyadic relationship and can learn about it only as reported by the partner who is directly involved in the therapy.

2.3.3 The quasi-interactional system: Here the therapeutic goal usually involves systematically changing and improving the interaction of the dyad. This could incorporate behaviour modification techniques and principles. Learning theory principles which attempt to directly alter the interactional pattern of the dyad are underemphasised in the quasi-interactional system.

2.3.4 The interactional system: This framework focuses on the individual, but is mainly concerned with how the person actually interacts with others, thereby introducing the possibility of belonging to a group.

Group processes are the primary therapeutic focus, and secondary consideration is given to inra-psychic phenomena. The goal is improvement in one's relationship with others and with the individual's feelings about themselves.

2.3.5 The transactional system: Transaction deals with the process of inter-relationships in an historical and relational context. This in other words means that the couple in therapy becomes the 'whole system'. The 'Gestalt' of the framework operates in such a way that any change in one member, has an impact on the couple's system and any significant others. The focus here in therapy is on a higher level of abstraction. In terms of the on-going interaction of the couple, the relationship is seen as a totally integrated system which functions at many different levels. In sum, it may be said that the goal of the framework highlighted here is the improvement and growth of the individual and/or couple. This goal is most pronounced in the intra-personal system as well. Emphasis on the intra-personal system becomes successively less intense as one moves toward the Transactional system where the goal is more the improvement of the inter-relationships of a couple and their interaction with significant others.

Walsh (1983)[15], narrows the above system into two main camps of marital (couple) and family therapy. She discusses the Growth-Orientated approach in which is included the psychodynamic-transgenerational, 'Bowen systems therapy', and experimental models.

The other group of approaches includes structural, strategic, systemic and behavioural models. These are categorised as (the) problem solving approaches. The writer deems it necessary to have a brief understanding of (and to highlight the distinction between) these two approaches. This is done in order to better appreciate the writer's preference for the growth-oriented approach as the choice of treatment in couples therapy.

Growth-orientated approaches.

The psychodynamic and transgenerational approaches of couples therapy have their origins in the psychoanalytic tradition. This would then incorporate the first two system frameworks in Olson's table 1. ie Intra-personal and Inter-personal systems. Symptoms are viewed as resulting from largely unconscious dynamics: attempts by people to re-enact, externalise, or master intraphysic forces/conflicts originating in family of origin relationships.

Current relationships are shaped and interpreted to fit these needs. The author describes an "interlocking of projection and introjection" processes between spouses. The symptomatic or presenting member may serve as an index or scapegoat for unresolved past or current family conflicts.

The theme of loss plays an important role in this approach ie. unresolved grief expressed by symptoms in one or more members of that particular system.

The aim of therapy, is for the couple to confront and deal with one another directly, in order to work through unresolved conflicts.

The role of the therapist is that of catalyst, actively encouraging the couple's awareness of intense conflicting emotions, interpreting their origin and consequences, as well as identifying their "shared" defence mechanisms. Simply put, the therapist in direct confrontation makes the couple's covert processes overt and accessible to treatment solutions.

It can be said that action is encouraged in order to confront and resolve unfinished emotional issues (or those which are trapped) eg: suggesting that a client visit a deceased parent's grave.

In essence, the resolution of couples conflict involves insights and "emotional working through" of those influences and resulting conflicts. Where this does not take place, and where unresolved grief issues impact on current relationships and functioning, the task of resolution of grief and guilt around the past loss and relationship cannot take place. Therefore, no resolution of these issues can result. Current relationships are thus contaminated by past, as yet unresolved, issues.

Murray Bowen, (1961)[16], developed a theory of the 'family emotional system' and a method of psychotherapy designed to help individuals to differentiate themselves from their families of origin. In this psychodynamic model, the goal in therapy is to assist individuals to achieve a higher level of differentiation and reduced anxiety as related to contact with the family of origin. Improved functioning is predicted when as a result of therapy, emotionally reactivity is no longer an irrational process. The author assumes that problems experienced by couples in their relationships can be resolved with an increased, healthy separation from their extended family or families of origin. (This is to be discussed in depth in Chap 3.2)

In the experimental approach, current behaviour and feelings are seen as the responsibility and result of 'the experience' of one's own life. Interestingly enough, here 'old pains' are made stronger by bringing them to the surface. The concept in couples therapy then, is to work on individual self-worth. The meaning and value of the relationship is explored in relation to the other partner. This is believed by the therapist to be "changeable" and correctable, should this be required or indicated.

In sum, the goal of these growth-oriented psycho-dynamic approaches in couples and family therapy, is a fuller awareness and appreciation of the self in relation to others. This is done by means of providing an intense, 'effective' experience in the sharing of feelings. The approach is characterised by the exploration, experimentation and encouragement of spontaneity of members responses to one another in the here-and-now. Some exercises particular to the phenomenological approach may be used to facilitate the therapeutic process.

2.4 The Problem Solving methods: an alternative to the Psychodynamic approach.

In marked contrast to the above-mentioned approaches, there are the problem solving approaches. As this dissertation presents the psychodynamic approach as the main treatment of choice, the discussion concerning these approaches will be limited to a brief overview of the treatment goals of these models which are aimed at modifying problematic behaviour in the client's relationship.

Segraves (1982)[17], notes that in many ways the problem solving approaches to the treatment of couples discord appear to be the "polar" opposite of the psychodynamic approaches. Whereas analytical therapists tend to view the issues of present behaviour 'residing' in the unconscious past of individuals, problem-solving or behavioural therapists working with couples, tend to emphasise their belief that the important issues of behaviour are

current and take place 'outside' of the individual in the inter-personal environment. These therapists then tend to focus their attention to modifying current, observable behavioural patterns. The inner meanings, and past, receives very little attention. They also employ a language system alien to the dynamic therapist ie: reinforcement and stimulus control; rather than that of 'unconscious libidinal drives'.

Listed below are a few of the major examples of the Problem Solving approachs:

1. Structural couple/family therapy
2. Strategic and systematic models
3. Behavioural learning approaches
4. Multiple couples in groups
5. Crisis intervention techniques and strategy
6. Social network intervention.

In returning to the psychodynamic treatment approach, the writer proposes that a fusion-model of "intra- and inter-personal systems" approach, coupled with an appropriate technique (to be discussed later) could equip the clinical social worker with a most effective form of intervention. These concepts are to be discussed in greater depth in the following chapter.

Chapter 3

3.1 Principle concepts of the Psychodynamic treatment model in Couples Therapy.

Nelsen (1983)[18], notes that most therapists adopting this approach, tend to rely on the use of ego psychological theory to understand the individual personality components and interaction in the dyadic situation. This, plus the incorporation of communications theory and techniques of couples assessment, gives the practitioner an excellent medium in helping to analyse what leads people in intimate dyadic relationships to apparent disharmony confusion and chaos.

Assessment in the Psychodynamic Model

In assessment, psychodynamically-orientated theorists assume that a couple's relationship and interaction is heavily influenced by the individual person's personality functioning.

Traditionally, the therapist may examine the individual's ego state functioning, perception, thinking, judgement, memory, ability to express affect, defence mechanisms and, most importantly, the ability to relate to others in a "healthy way".

This is done primarily to assess the structure of the individual's strengths and areas of dysfunction. The client may make excessive use of defences in dealing with needs and feelings. These are indicative of intrapsychic conflicts in which the present is possibly misjudged in terms of the past; eg: a man may inhibit expressions of dependency on his wife because he unconsciously fears that she would reject him if he did not. The fear may stem from a past perception that his mother rejected him when he acted dependently. As the

fear is not in the man's consciousness, he may not try to express the dependency in an adult situation to test the response. If he does let some of it out, he may then think that he has received the feared response even when he has not.

Psychodynamic theorists see dyadic interaction patterns as developing from compromises that adult individuals make to meet each others needs and avoid threatening each others defences.

If we look at the above example, the too-dependent man may have married a woman also afraid of dependency, yet who persists in denying it. Both partners may then defend against facing their dependency needs. These needs might be met indirectly through having other "hidden relationships", resulting in one partner feeling unloved by the other, who in fact, is dealing with the same needs, yet in an indirect fashion.

In this way, psychodynamic theorists assess the functioning or dysfunctioning of dyadic relationships. All important are family life-cycle stages, physical and environmental factors such as clients' health or employment. Issues concerning the uncovering of insight are important especially the ability to think and act without being blocked by intra-psychic conflicts.

Psychodynamic theorists believe that people can function better when they gain insight into why they are having problems. Clients are then encouraged to translate insight into action. Partners are made aware of their interactional patterns, especially those patterns which are dysfunctional. They are sensitised to their own feelings and their irrational fears which may be keeping them from altering or adapting their behaviour. Past experiences that may be

distorting their understanding of the present are explored.

The primary means toward the goal of improving the couple's insight is, as in individual treatment, the therapist's interpretation of the couple's intra and interpersonal functioning. As an adjunct to therapy, additional techniques through which psychodynamic therapists help persons become much more aware of themselves and others, is through the exploration of reasons for behaviour. This is the giving of support to help individuals to be less afraid to reveal themselves; and the modelling of openness by therapists' expressions of their own feelings. Much less emphasised, but used by psychodynamic therapists, are techniques which interrupt dysfunctional patterns directly, such as the giving of homework tasks to the couple. Practitioners sometimes give educational information and advice, and at times intervene in a practical manner (with the client's permission) in their environment.

3.2 Intra- and Inter-personal phenomena: Emphasis on personal dynamics when treating discord in dyadic relationships

Huneeus (1963)[19], notes that "Each individual unconsciously strives to come to terms with those parts of themselves that they feel are unacceptable, and unconsciously they strive to choose a partner who will help them do so".

The thinking then, in respect of the above, is that the parts of the partner's personality that are not recognized, are projected onto the other partner who acts them out and expresses them. The dynamics of most couples relationships may be said to consist of the bits and fragments of the hated, feared, repressed and unacceptable parts of their own personality projected by one partner, and absorbed and expressed by the other.

Given this, the treatment philosophy in the writer's opinion for psychodynamic therapists, for example, could include the work of Melanie Klein (1952)[20]. Her concept of projective identification represents the fantasy of forcing the self in part or as a whole into the inside of the other object in order to obtain possession and control of it, whether in 'love or hate'.

Seen in this way, the therapist can have great insight into the philosophy of treatment in couples therapy. It can be adapted to the couples situation effectively and may be used by the psychodynamically orientated therapist in family therapy as well.

One of the biggest problems in treating couples, is that of knowing how to help them alter their attitudes and their behaviour significantly, without taking the long and time-consuming exploration of early experiences that is involved in traditional psycholanalysis. The writer is of the opinion that the above concept is basic to psychodynamic work with couples, and that what is needed now, is to stress the importance of taking this concept and applying it in a functional way, well within the skills of the clinical social work practitioner. (This is to be discussed in Chapter 4 (4.1)

Inter-personal interaction

Nathan Ackerman (1958)[21] notes that "in undertaking to diagnose couple's relationships we are not only concerned in the first instance with the autonomous functions and pathology of individual personalities, but rather with the dynamics of the relationship, that is, with the reciprocal adaptations that define the relations of one partner interacting with the other".

Florence Hollis (1964)[22] provides the following direction when she writes "central to casework, is the notion of the person-in-his-situation as a three-fold configuration consisting of the person, the situation, and the interaction between them".

As such, the clinical social worker is concerned with improvement in social functioning, which frequently requires dealing with both interpersonal and intrapsychic conflict in order to effect desired behaviour changes.

In treating couples within the psychodynamic framework, the above-mentioned principles are no less different. We still have to respect and promote dynamic and developmental understanding. The difference is that it is done between two people rather than with one person.

When we consider dynamic factors within the client or the dyadic relationship, we are simply helping the persons concerned, to further pursue some of the intrapsychic reasons for their feelings, attitudes and ways of acting. We are helping them to understand the influence of their personality and characteristics in reaction to, and upon one another. In other words, how their thoughts and emotions work in the context of their relationship.

The author notes further that the therapist, in working with a couple in therapy, must go beyond trying to understand single interactions or even a series of interactions in the person-situation gestalt. The therapist must consider the intrapsychic pattern or tendency that causes the interaction.

It is important to encourage reflection in terms of developmental dynamics when counselling clients. This has important implications when it becomes apparent that factors in one

partner's development may be blocking any potential growth in the dyadic relationship.

It is important to help the couple become aware of the way in which certain of their present personality characteristics have been shaped by their earlier life experiences. Certain dysfunctional characteristics cannot be overcome except by insight into those experiences that contribute to their formation.

In all dyadic relationships, certain patterns of behaviour persist, although they vary during the different phases of the relationship. Most external issues concerning the couple are bound to affect the two partners differently, and may upset the balance of their interaction.

It is the writer's belief that the resulting conflicts in clients can only be understood effectively if they are viewed dynamically. Conflicts are to be seen in relation to the client's early life experiences, which, in the writer's opinion, are chiefly bound up in the client's relationships to their biological parents, guardians or others during the formative and adolescent years.

The Using of Family of Origin Material in Couples Therapy

Fontane (1979)[23] notes that "the relationships couples have with their families of origin, are multifaceted. Day to day interactions present a potential for supportive relationships that can enhance the overall quality of a couple's life, but such relationships also carry a potential for destructive conflict".

Of special importance to therapists is another aspect of family relationships: the way in which the present relationship of a couple is affected by past relationships in their

families of origin - especially the marital relationship of the couples' set of parents.

Unfinished Business from the Past

During the therapy process, Fontane(1979) focuses attention on the possibility of couples raising issues regarding current conflicts with family members (family of origin). The therapist can work with the couple on these issues. Attention is paid to the here-and-now (as a basis for the presenting problem), also with aspects of these issues that relate to unfinished business from the past.

As the relationship of all couples (and individuals) is influenced by the places from which they have come, the ways in which they "grew up" feeling about themselves, and about how people treat each other, the therapist should foster routine discussion of family of origin material with all couples in therapy so as to gain greater insight into the "dynamic climate" of the client's past.

Overadequate-Inadequate Relationships

Two people who select each other, have reached the same basic developmental level (although they are not necessarily performing at the same functional level). This dynamic way of thinking is helpful in working with couples who are in a committed relationship. The "overadequate-inadequate" relationship phenomena, noted by Fontane(1979), is such that one partner makes the decisions and the other is "helpless", but the two are equally immature. In looking at their parents marriages, these clients often find previously unrecognised similarities in their own marriage interactions.

Expectations: The unwritten contract in couples relationships

The idea of a "couples contract" has emerged over the years. This idea is that each partner carries into the relationship, an individual, unwritten contract, a set of expectations and promises, both conscious and unconscious. Fontane (1979) emphasises that contractual terms may be divided into three parameters: (1) the expectations of the partner in the relationship (2) the intrapsychic and biological needs and (3) the problems that are actually rooted in the first two categories.

Many important contractual expectations follow directly from assumptions based on one's previous, most intimate encounter with others who are involved in committed relationships (usually that of one's own parents). Thus the sources of contractual difficulties encountered, actually vary greatly. One classic source of "contractual difficulty" stems from culturally determined sex-role differences as perceived by the culture of a particular society or community.

When the partners' families of origin have widely divergent assumptions or values about what constitutes appropriate behaviour in terms of sex role identity, choice of same sex partner, or the "appropriate behaviour" for wives or husbands, the "new couple" faces a substantial task in examining their own assumptions and areas of conflict. They have to find a set of mutually workable expectations for themselves. These may include such areas as the display of emotions; also differences in definition of "sex-typed men and women's work" all of which might cause conflict, chaos, confusion, and discord.

Some couples decide together on a "new" value system or a value system in which a non-traditional sex-role is a fundamental aspect of the couples' relationship:- i.e. "same-sex couples".

Functional use of Family of Origin Material In Therapy

The gathering of information about the couples families of origin has been used by various therapists.
Therapists ought to recognise differences in the two families and between the partners themselves. They should look at how the partners have difficulty in handling these differences.

Discussion of the partner's family of origin material readily tends to elicit material relevant to hidden contractual terms.

As clients discuss their parents' marriages, they verbalize some of their feelings about how partners should treat each other and the similarities or differences in their parents actions. This kind of discussion often brings out previously unverbalized assumptions and expectations that each partner has not expressed of the other.

Problems in couples relationships may arise from incomplete "separation-individuation" and hopefully a therapeutic relationship offers the opportunity for growth. The task of the therapist is to help each partner to master their own individual separation-individuation, away from the bonds of family of origin and which will free that individual to employ developmental opportunities in the current relationship.

The goal of treatment is seen as the achievement of a higher level of differentiation of the self. This kind of material

is closely integrated with problems in the relationships from which the partners have come.

Gaining awareness through discussion of family history, brings to light some separation-individuation material and thus enables the couple to work through a portion of this material. Any amount of movement can represent an important gain.

It is especially important to discuss the way in which the couples' parents or caretakers demonstrated - or did not demonstrate - love and affection, especially to each other, as well as the way in which they handled power issues, differences, anger and how they related to their children or those in their care.

Fontane(1979) suggests that couples should guard against the negative expression of the above mentioned emotions. This could be done by (1) directly verbalising areas of conflict and (2) by not projecting their symptoms or presenting problems on to one or more of their children (if they have any) or any other person with whom they, as a unit, interact.

There are different sets of dynamics which the therapist must consider if the clients have, for example, been the targets of a projected parental conflict or were themselves expected to assume a parenting role. If they observed one parent taking on the role of "sick person" for example, or if they learned from long observation that to be involved in a committed relationship meant to be in constant, overt conflict, different dynamics would apply.

Discussion of the past, the present and the similarities between the two, can help elucidate some previously-unrecognized reason for a couple's current unhappiness. This often aids the working through of old unresolved, and

present pains. The concept of "working through" represents an important part of the therapeutic process; it involves accepting what was and is no more, a coming to a greater understanding of a previously troublesome emotional issue.

Fontane (1979) notes that "One need not continue to act like the child one once was: one's partner is not one's parent and one need not expect he or she will act the way that parent did".

A related aspect of the working through process, has to do with making peace with members of one's family of origin, whether in life or in memory. This process is important because the more intense the cut-off with the past, the more likely the individual(s) are to have an exaggerated version of their parental family problem in their own relationship.

History of Parents' Marriage

During the initial sessions, the therapist should present the procedure of discussing the relationship of both partners parents. It ought to be conveyed to them that this is a routine part of the counselling procedure, and that this kind of information sharing is generally useful and interesting.

The therapist can explain, in varying ways (depending on the couples level of understanding) the reason for this procedure. The actual history-taking of the marriages of parents, need not be lengthy in short-term treatment. The writer does this by way of taking a fairly detailed genogram sketch not only of the parental subsystem, but of the whole family of origin, nuclear and extended.

The notation used is the internationally accepted method of recording and includes certain ecosystems and lines of relationship as well.

At this point the writer usually uses a self-developed style of notation to indicate the intensity of interpersonal relationships.

The writer finds that one or two sessions will suffice for both partners, who take turns in sharing with the other partner and with the therapist, their recollections of their own mother's and father's relationship and the dynamics which were particular to their parents'/caretakers' interaction.

According to Fontane(1979), most couples readily grasp that this kind of discussion relates directly to the request they made for help. It is relevant, and the couple usually are able to "cope with" the material. It can be seen "to make sense" because the discussion clearly connects with the problems in their own relationship in a meaningful way.

Much of the material here is conscious or at least readily accessible (preconscious). Depending on the couple, the therapist will guide the session with varying degrees of intensity. The couple may undergo a useful learning experience along with a positive sense of accomplishment about the therapeutic process itself.

Separation - Individuation Process

The chief use of the history-taking is its potential for the facilitating of the separation-individuation process by the partners.

The process of even looking at one's parents' relationship helps in the differentiation process. It helps the clients see their parents as people, not simply just as parents, that they and their parents are separate human beings.

Any movement away from symbiosis with the parent/s represents growth. Any gain in level of maturity represents a gain in the way the individuals feel about themselves and in their ability to relate to their partner. The separation-individuation process is lifelong and is never really fully completed. It does, however, provide ongoing opportunities for continued growth and development for clients if they are able to negotiate this form of separation anxiety.

Bringing to the surface a previously inaccessible pattern of thinking and relating renders that pattern amenable to alteration. This is in line with the dynamic approach and dovetails with the psychoanalytic school of psychotherapy.

The combination of insight, along with an enhanced sense of hopefulness about the ability to make changes in expectations and behaviour, enables a couple to "feel better" about themselves and to move forward toward functioning at a more mature level.

Gains in other areas of functioning

The couple's ability to make gains occurs because the therapeutic process facilitates interaction. A couple first achieves some practice and subsequent success in discussing material in terms of "feeling tone". The writer sees this as less threatening than the issues that have been brought into therapy.

Having taken the opportunity to discuss some subject involving feelings and having been able to be supportive to each other, they can now risk discussing (at least at some level)

other subjects involving their inner sensitive feelings and emotions.

Assuming the couple achieves some success, the partners can become more optimistic, less hurt and angry. They are thus more able to "give" to each other, by talking and by listening to each other.

This enhanced ability to "take risks" goes hand-in-hand with the achievement of a "gratifying sense of accomplishment" from work done together. This dual sense of achievement has the potential to be generalised to a better overall relationship.

Using the material in diagnosis

Another use of this process, is for diagnostic purposes. The author suggests that taking a family history "does no harm". The couple are not forced to talk about any issue that they are not ready to discuss.

Psychodynamically, where there is little ability to recall any aspect of the parent's marriage or little ability to make connections, there is evidence of "genuinely repressed material". This is perhaps indicative of either past major trauma, or of a fairly close personality identification structure with the parents of the client. What is meant here, is that some client's remember their parents as having a "perfect marriage". This is when only positive material comes to light - and little or no negative issues are recalled. This would then indicate that the couple may have a limited ability to deal with deep-seated, still very painful issues which remain unreached and unresolved in the client's current relationship.

If this dynamic is active, the author suggests that the therapist needs to help the client(s) accept these emotions

and that clients can be helped to realise that disaster need not result from reaching and expressing painful and angry feelings which they might be harbouring towards their own parents.

It is important for the therapist to learn how different the two families of origin are. Also how widely varying the expectations each partner has of the other in this regard.

The therapist may choose to help a couple focus on an area, in which differences are not drastic. This is done in the hope of achieving some resolution of the issues concerning each partner's "private agenda".

How rigid are the family systems from which each partner comes? How much emotional warmth was present in the family atmosphere? The degree of rigidity in these areas, along with the amount of difference between the two families, has implications for the present conflict and the possibilities for resolution. Has one of the partners identified the other with the parent figure? If so, then to what extent?

The author notes that the answers to these questions, which are obtainable in part from the sharing of family of origin material, have great prognostic and diagnostic importance in the therapeutic process, and should form part of the assessment procedure as a matter of course.

3.3 Some aspects of Transference and Counter-transference in Psychodynamic Couples Therapy.

No discussion concerning psychodynamic therapy is complete without taking into account the transference and counter-transference phenomena. In the treatment of couples, the transference and counter-transference features are central to the therapeutic framework.

Appel (1966)[24], discusses the "triadic relationship" in couples counselling. In the therapeutic relationship, the couple reveals to a "stranger" that which is usually considered to be their private lives. For the partners as clients, there is more involved than the issues of being exposed and being dependent on the therapeutic relationships.

By way of example, if the therapist is male and the client female, she may have to "live out" a new experience with men, with her partner and with the counsellor. She might have to face on a deep level with a male, problems related to her femininity - perhaps fear of closeness to men. The same holds for the female therapist and her male client(s).

Manifestations of transference

The partners as clients in the course of psychodynamic treatment, may find themselves in conflict on several levels. While motivated to seek help from the therapist and perhaps experiencing positive feelings toward the therapist, either or both partners may, for example , see the therapist as a sexual competitor in a situation in which their sexuality is challenged.

On a conscious level, the client(s) may be comparing and contrasting their own physical, social psychological, sexual and economic attributes with those of the counsellor. The issues that arise in terms of intra-personal material as yet unresolved, may be linked to an un-negotiated developmental stage in the client's life. Conflicts may be re-experienced, with their associated hostilities, fears and anxieties. In all, intimacy and 'risking' with the counsellor often re-activates intra-psychic phenomena which must be dealt with if the therapist is to work within the psychodynamic framework. It is vitally important for the therapist to be aware of the

psychodynamics operating within the client system at this point. At the same time the therapist must also pay attention to and analyse the transference/countertransference material that must arise in therapy. In the writer's opinion, this "double task" of the therapist in treatment is an integral part of the psychodynamic approach when working with clients who are experiencing interpersonal difficulty.

Manifestations of Counter-transference

Appel (1966) notes that a client who characteristically employs seductive behaviour as a manipulative manoeuver, is likely to carry this behaviour into counselling and may stimulate not only jealousy with his or her partner during treatment, but also strong counter-responses in the therapist.

Erotic, competitive, hostile and anxious oedipal reactions may be activated in the clinician. The therapist is bound by professional ethics to keep these in check. Appel (1966) also notes that counsellors who fear loss of control of their own impulses experience a 'near state of panic'. The therapist's resulting anxieties reduce the client's ability to deal with the unconscious purposes of their (client's) 'seductiveness'.

It is important for therapists to be comfortable with their own responses, to accept a client's feelings and behaviour as part of the client's symptomatology when working within the pyschodynamic model. The therapist's acceptance of a client's freedom to discuss transference issues and to explore patterns of relating, will have a therapeutic effect in terms of the treatment.

Discomfort on the therapist's part in responding to the sometimes manipulatory dynamics as described, fosters discomfort in the client. This often arouses strong feelings of shame, dysfunction, ridicule and rejection in the client.

It is the therapist's responsibility to alleviate any such feelings as and when they are 'discussable'. This is a crucial part of treatment. The therapist should be able to accomplish this when helping the client to discuss and work through the related dynamics. The impact of dealing with these issues can, in the writer's opinion, only enhance the working relationship.

Should a therapist choose not to deal with the counter-transference material, the possibility of "therapist withdrawal" from the treatment programme might take place. Also the therapist may ally him/herself with the "other partner" thereby avoiding conflict with the client who is seen as the source of the counter-transference.

On the other hand, the therapist's conscious feelings of jealousy or competition with one of the clients/partners may arise as well as fantasies regarding 'combat' for the affection of a particular partner. The unaware counsellor may join "his/her partner of choice" openly or subtly, in mutual seductiveness with the aim of ousting the "hostile" partner. At other times the therapist may ally with one partner's resistance to treatment and unwittingly help the other partner to withdraw.

The therapist may respond, of course, to any other behaviour exhibited by the couple. Of note specifically, may be the therapists' projection of their own dyadic relationships on to the couples they are treating. This phenomenon should be worked through with the therapists in their own supervision (or therapy).

Therapeutic use of the Relationship

Therapists faced with an emotion-laden triadic relationship, have the responsibility of attempting to help their clients to

work through as much as possible. This includes any emotional reactions within the therapists themselves. (This is done in order that their professional relationship with the client(s) is not impaired). Only when the therapist is free to respond to the emotional currents generated by the three-person relationship, can the therapist make therapeutic use of the clients' responses.

The particular themes that develop, will vary from client to client, couple to couple. It is the therapeutic relationship which will remain as the medium for the assessment of the clients' growth from dependency, hostility and/or isolation.

Through careful assessment of the clients' reactions in joint and individual counselling and an examination of their total life functioning, past and present, the therapist can develop themes for treatment. These can be interwoven with similar perceptions gleaned from other situations reported by the couple.

Other therapeutic considerations

Joint interviewing, by its structure, increases communication within the couple's relationship. The very nature of 'sharing' in therapy can foster closeness in the couple's relationship.

Some contraindications

Many couples are so bound by mutual distortions and rage, and the need to maintain mutual and individual pathology, that for either or both partners even the beginning of objective self-assessment can take place only in the absence of the other partner. These couples, especially at the beginning of treatment, only seem able to use shared treatment revelations destructively in their relationship. Also, although the need for secrecy regarding pathology is often exaggerated by the

therapist (because of his/her own anxiety), there are some areas of intra-personal life that arguably should remain private and some pathology that is best treated in the one-to-one client therapist relationship.

In sum, focussing in depth on transference phenomena is only possible and indicated in cases where clients truly desire and are capable of personal introspection and insight.

The writer feels that to underscore the transference and counter-transference issues, as they interact in the triadic therapeutic situation, would be counter-productive to the treatment mode as a whole. Successful psychodynamic therapy contains these dynamics. It is up to the therapist to acknowledge this and deal with it in a responsible and professional manner.

3.4 Techniques in Couples Therapy: an overview of Current Alternatives

Sager (1967)[25], notes that a variety of techniques directed towards couples therapy have emerged over the past thirty years.

Psychotherapy of couples centres on an effort to alter the behaviour and the interactional dynamics of two persons who are involved in a committed relationship.

The treatment of couples differs in technique from other modalities in its specific focus on the couple and their continuing relationship, rather than on the individual. At the same time, there is emphasis on treating two individuals who are unique.

Such persons enter treatment with a background of common experience and reactions and continue their relationship with

each other while treatment proceeds. The results of couple therapy should be evident not only in the relationship, but in all other aspects of the couple's activities in which problematic behaviour, similar to that which is experienced in the relationship, is encountered.

To practice this form of therapy, the therapist must obviously believe in the individual's ability for and willingness to be involved in a committed relationship. Above all, the couple must believe that the relationship is worth maintaining and that they are motivated to do so.

The therapist must also accept the right of the couple to dissolve the relationship. This is when it is destructive to all concerned and when the couple is not motivated to continue the relationship and where serious efforts to alter the situation have failed. The therapist must be flexible in methods employed and goals developed as treatment proceeds.

At present there are several clearly defined types of couples treatment using dynamic approaches aimed at producing both intrapsychic change and change in the inter-relationships of the couple.

Listed below are a few of the most important techniques or "mediums" through which therapists are able to implement their particular approach.

In the writer's personal opinion, a combination of the conjoint and concurrent techniques serve the psychodynamic approach in couples therapy best. As such, a more detailed discussion concerning these two techniques and their applicability in practice is propounded later in this chapter.

3.4.1 Techniques currently in use by therapists when treating couples

1) Classical (one to one)
2) Concurrent (simultaneous treatment of individual partners at different times)
3) Collaborative (stereoscopic or double view)
4) Conjoint (simultaneous treatment of both partners in joint sessions at the same time).

It is important to discuss these techniques as they (or their combination) may be applied to the treatment of the couples. The therapist may choose a particular combination of these techniques according to their preference. This could then be in accordance with the therapeutic approach used in the treatment model of choice.

3.4.2 Classic treatment in Marital disharmony

Giovacchini in Green,(1965)[26], describes the above technique as a dyadic, one-to-one relationship between the therapist and his/her client. In this type of treatment the therapists of each client/partner do not communicate. Thus confidentiality of all the transactions between the therapist and the client is crucial.

In the classic technique, therapy is focused on the problems of the individual within themselves or their relationship to the world outside themselves. The focus is on individual psychodynamics with the partnership as the backdrop. The patterns of behaviour raised in treatment receives selective focus on how the partners react to these patterns.

3.4.3. Indications for the use of the Classic Technique

a) Therapists knowledge of acting-out behaviour by one partner of which the other is unaware.
b) Personal preference of one or both partners.
c) An emotional immaturity may exist in a partner which precludes sharing with the therapist.
d) One partner feeling the need to receive treatment irrespective of the consequences to the other partner.
e) Where it is evident that one partner has widely differing goals in terms of the couple's relationship.

3.4.4 The collaborative technique in Couples Disharmony

Martin in Green(1965)[27], notes that in this technique, both partners are treated individually but concurrently by separate therapists. The therapists then communicate with the knowledge and permission of each marital partner.

3.4.5 The following are indications for the Collaborative Technique

a) The opposition of one partner being treated by the same therapist as the other partner
b) Initial hostility of one partner towards the therapist.
c) Referral from another therapist because of the client's personal reasons, eg. being uncomfortable in the triadic situation or non-acceptance of the frame of reference of triadic techniques.
d) Referral from another therapist because the partner has created therapeutic complications, and it is evident to the referring therapist, that the couple have widely differing goals in terms of their relationship problems. Should the couple separate, it may be necessary for the two therapists not only to supply on-going emotional support to each partner, but also to help in structuring the various family arrangements.

3.4.6 The Concurrent technique in Couples Therapy

Mittleman (1948)[28], described for the first time the nature of this technique. In this approach, both partners are treated individually but by the same therapist. This in actual fact lays down the foundation for the first triadic clinical setting for the therapist. This technique is of great value in treating couples discord when a therapist must deal with elements of the interpersonal system (as described earlier).

3.4.7 The indications for the use of this technique in couples disharmony include the following:

a) Where the requirements of the committed relationship of one of the partners has overwhelmed the other partner.

b) Where insight into their behaviour patterns as they affect each partner is needed to produce alteration in behaviour.

c) Where a test of counselling procedures has indicated that one or both partners could profit from a deeper understanding of the components of their three system, i.e. interpersonal, intrapersonal and environmental.

3.4.8. Therapeutic Elements and Therapeutic Action of this Technique

Concurrent therapy contains specific therapeutic elements and a therapeutic action inherent in the design and composition. A couple who are under considerable stress react to concurrent therapy with feelings of emotional support and with relief from their anxiety. An important therapeutic

element in concurrent therapy is the multidimensional view of the relationship. Insights gained by the therapist from the clients' communication are often seen as contradictory and constantly changing. Through the triadic communication system, important knowledge is gained in minimal time. This includes both the nuclear and kinship transactions. There is also some understanding of the immediate and peripheral environmental situations.

The therapist hears the symptoms as reported by the couple. The partners are aware that the therapist is hearing both sides of the complaint. As the concurrent therapy proceeds, partners frequently discuss between themselves ideas gained through insights. Particularly in the later phases of therapy, this type of communication may become an extension of the learning process.

On the other hand, these incidents often reveal to the therapist additional information about their clients' resistances and the significance of the frustrations, resentments or projections produced by these 'inter-partner' communications. The communication of unconscious sibling-rivalry attitudes or oedipal feelings, as highlighted in the triangular representation of the family of origin i.e. clients and their parents, is a further therapeutic element. This, in the writer's opinion, is crucial to psychodynamic therapeutic process and treatment.

Another distinctive therapeutic element in concurrent therapy is the triangular transaction process. Green and Solomon (1963)[29], have differentiated three focuses of transactions in the transference relationship.

1. The first transaction involves the relationship to the therapist as a real person, and subsequently, as a new object as well.

2. The second focus of transaction refers to those situations where the therapist is experienced as a symbolic figure possessing qualities relating to their clients' existing fantasies (such as those involved in projections and displacements).

3. The third focus of the transaction concerns the regressive phenomena evident in the dyadic or one-to-one transference situation as explained by the client themselves.

These three focuses of transactions between client and therapist are fundamental in all therapeutic relationships. In concurrent therapy, because the transference reactions of both partners are directed towards the same therapist, as well as towards each other, two directions of transaction related to the triangular transactions are introduced.

The authors note that the first is the "triangular transference neurosis", such as the reproduction of the oedipal situation. Here we see a regression of one partner who sees the other partner and the therapist in "collusion". The second, the "triangular transference transactions", concern the production of a dynamic feedback, not only toward the therapist, but also to the other partner, who in turn can feed back to his/her partner, to the therapist or to both.

Interpretations of the transference phenomena in concurrent therapy are made from the frame of reference consisting of both the dyadic and triangular aspects of the transference. The additional focus of transaction increases or favours the increased production of emotional and intellectual insights, as argued by Green and Solomon. This, in turn, is conducive

to the learning process and forms an integral part of the technique and clinical process so necessary in psychodynamic counselling.

3.4.9 The Conjoint Technique in Couple Counselling

For many years the literature of social workers has been filled with references made to joint interviewing of couples with problems. In 1959, Jackson first introduced the term conjoint therapy in psychiatric circles in the United States.

In this approach, both partners are seen together by the same therapist in the same session. It is also the most commonly-used approach.

3.4.10 The indications for Conjoint Therapy in Couples Treatment are:

1. Therapeutic deadlock in the concurrent approach.
2. Suspicious or paranoid behaviour of one partner who reacts with anxiety and who distorts the comments which either the therapist or the other partner are reputed to have made in the individual session.
3. Economic - the cost of the treatment is halved.
4. Explosiveness of the couples relationship might demand speed in bringing order to the couple's environment and/or family.
5. Couples in a relationship where the problems are largely of an acting-out nature.
6. The need to foster communication between the partners.
7. Couples who perceive relationships between events - this needs attention.
8. To point out not merely the difference, but the possibility of complementing each other in the transactions (between the partners).

3.4.11 Contraindications for Conjoint Therapy in Couples Discord are:

1. Where one partner suffers from severe psychosis.
2. Where there is a regressed excessive "sibling-like" rivalry and where the keeping of secrets is the main objective in "punishing" the other partner.

The conjoint treatment technique has been found by most therapists to provide more access to both the partners' dynamics.

In some couples, conjoint sessions give the advantage of heightened perception. There is also the immediate advantage of direct observation of the participants who are experiencing the problem. This facilitates more objective evaluation of the partners' behaviour and limits the need to judge distortion from a more indirect source. Witnessing the couple's relationship in action affords an opportunity to observe the non-verbal transactions of the partners.

With both partners in the session, the therapist can observe the healthier side of the relationship - the positive strivings and values.

Where and how the couple join in "healthy striving" is more difficult to perceive or infer from individual interviews but easier in the conjoint sessions.

An important advantage of conjoint treatment is the opportunity afforded the partners, via the therapist, to receive a lesson in communication. Frequently when one partner is more verbal than the other, the therapist can turn to the more silent partner to ask their reaction/s to the other's comments. This enables that partner to express their

feelings when the other person speaks or behaves in a certain manner.

At times the couple may appear harmonious during the sessions, but disharmony can arise shortly after leaving the session. When this occurs, it is suggested that they express their conflicts in the office where these can be explored.

Similarly, in conjoint sessions, a couple can work out reality problems which they have not been able to solve at home. The dynamics of the conflict which preclude a solution at home can be brought into the open in an effort to solve it while at the office. Further, the setting of limits in the relationship enables the therapist to structure it for exploration of the causes (variables) underlying the experienced disharmony. Another advantage of the conjoint technique, is the leverage it places on the couple to re-examine their reality testing.

When an interpretation of feelings or behaviour, frequently in terms of content and relationships in their transactions, is made to one partner, the other also hears it and may further discuss it outside the sessions. Not only does this improve communication between the partners, but in effect each partner indirectly provides the therapist with a "co-therapist" who may reinforce the interpretations made during the session.

Many therapists have found that joint interviews are far more effective than individual interviews in helping couples in distress. In joint interviews the therapist is able to observe the interpersonal relationship of the partners, their usual mode of behaviour towards each other, and their non-verbalised attitudes and feelings. In some cases, disharmony is resolved by simply focusing the couple's attention on the correction of their interactional symptomatic problems.

The value of assessing partner interactions can not be emphasised enough. It is the writer's opinion that the joint session is perhaps the only true method of the "acting-out" of the intrapsychic issue mentioned earlier. Once again, the value of the intra and interpersonal interaction assessment cannot be over-emphasised as an integral part of treatment in couple's therapy.

The writer sees the joint interview as not necessarily focussing solely on joint problems, nor does individual assessment focus solely on intrapsychic problems. Both emphases can actually take place in joint treatment with resulting benefit to the individual as well as the couple.

The presence of the therapist does not necessitate a change in psychotherapeutic methods or techniques, as they are applied to the individual problems of one of the partners. Therapeutic attention alternates between the partners. Alternate focus may fall on one or the other as the circumstances and material that arises dictates.

As discussed earlier in this chapter, the writer acknowledges that the treatment of choice, namely psychodynamic therapy with couples, must be linked to a viable delivery system.

Of the techniques mentioned, the writer has chosen a combination of the conjoint and concurrent.

3.5 Combining Conjoint and concurrent treatment within a Psychodynamic Framework: Linking Technique to method.

In terms of the psychoanalytic treatment of couples discord, the approach stresses the role of psychopathology in the individual partners as being primarily responsible for conflict in the relationship.

The approach hypothesises that unresolved early conflicts occurring in the family of origin of the individual partners are unconsciously replayed in current inerpersonal relationships. This model strongly emphasises the role of past experiences, subjective experiences and unconscious motivations in individuals. The hypothesis is that the disturbances will resolve when the disturbed partners resolve their individual "agendas".

Nadelson (1978) [30], describes a form of joint therapy that 'fits' the criteria for being called psychodynamic. From this perspective, unconsciously intrapsychic factors determine mate selection and the type of conflicts experienced. Early emotional conflicts are reactivated by the intimacy of the relationship which in turn activate defence processes that attempt to arrest these conflicts from awareness. The author hypothesises that "couples conflict" is not based on current reality, and is thus minimally influenced by current reality. Interpretation becomes a primary tool in treatment. The ultimate aim of psychodynamically-orientated therapy, according to Nadelson, is the "interpretation (and working through) of aggressive and libidinal needs so that behaviour is motivated more in the service of the ego and less by impulse and intrapsychic conflict".

3.5.1 Combining Conjoint and Concurrent Treatment Techniques in Couples Therapy.

In the combined approach of conjoint and concurrent techniques, the couple in conflict is seen in a variety of individual and dyadic clinical settings. The writer sees individual sessions consisting of the therapist and the index client or partner, whilst dyadic sessions consist of both partners seen together, with the same therapist, at one time.

The form of "combined technique" to which the writer ascribes, may be called the simple kind, i.e. a combination of individual, conjoint and concurrent sessions in various purposeful combinations. This is not to be confused with the combined-collaborative technique where each partner is treated individually by separate therapists. Here all four individuals then meet together at regular intervals.

The treatment process of the "simple combined technique" is based on a plan of active support including environmental manipulation, clarification of role expectation and acts. Included are redirection of intrapersonal energies and the enhancement of healthier communication between the partners.

Hunees (1963)[31] suggests that an increasing number of therapists are beginning to give more attention to the combined conjoint-concurrent technique in couples therapy. This possibility does not mean that the one to one (individual) dimension in couples therapy is to be replaced, but it promises greater scope for therapists in the choice of treatment methods.

When individual and dyadic sessions are combined, the interview structure takes on additional meanings for the participants. This form of combined approach can actively represent to the therapist important aspects of functioning in the relationship.

Clients may be regarded as incorporating three separate systems: 1) an intrapersonal system, 2) an interpersonal system, involving transactions with "significant others" and 3) an environmental system responding to the interplay of forces between the individual and society.

The writer sees these three systems being reflected in the combined approach through the use of the diadic sessions focussing on the other partner at the same time. One might interpret the therapist as representing an outside party. The process of treatment demonstrates the therapist's dual concern for understanding the origin of feelings as they relate to the couple's genetic past and their re-enactment of issues in the current relationship.

The conjoint-concurrent technique is perceived by the writer as increasing the perceptive awareness of all participants - the couple's as well as the therapist's. In dyadic interviews the aim is to eliminate distortions from communication so that covert and overt meanings and messages become identical. The opportunity to experience "different environments" highlights the contrast between individual and multi-personal relationships. This can bring out different sides of the personality that could well be lost in individual treatment.

The writer notes that there may be a tendency for therapists to make the mistake of assuming that a client will behave in the same way in all types of interview situations. The opportunity for feedback through the use of individual and dyadic sessions represents a corrective for a number of the therapist's misperceptions and misinterpretations.

The individual and dyadic treatment settings deal with different clinical material as presented by the individual or the couple. The 'individual' sessions reflect the importance of the intrapersonal system of each partner. In the individual session what comes to the fore is the individual's more deeply-rooted psychodynamic (unconscious or pre-conscious) personality components, whereas in the dyadic setting, the intersocial reality comes into focus. These two treatment approaches offer opportunities to work through different clinical material more adequately.

Asch (1952)[32] notes "the experience of the dyadic session is an important phenomenon. Experiencing the difference between the individual and dyadic situations being reacted to differently and observing the repercussions of one's behaviour and verbalisations on two or more individuals or it's interpretations, stimulates a desire to understand one's reactions. The dyadic interviews thus promote tolerance for the other person's uniqueness and integrity. They also represent a shift from ego-centred private areas, to areas of mutual orientation".

In the dyadic session the healthy and the unhealthy transactions can be expressed by the couple. Behaviour deemed to be inappropriate can be clarified "on the spot". Failures of the individuals partners in perception, interpretation of perceptions, communication and interpersonal behaviour, become the material which is dealt with in the sessions.

In the dyadic sessions the therapist witnesses the unfolding of the conflicts "as they happen". This enables the therapist to understand the dynamics much better. Anger may be expressed, but the presence of the therapist helps to soften as well as comfort the feelings of understanding and tolerance.

The couple then re-experience the family-of-origin conflicts, but in a different atmosphere: one that is conducive to learning and experiencing in a safe environment with the therapist as invigilator.

Each of the partners must be moderately secure in their own identity if they are to assume appropriate roles; to complement and support the other partner, to develop a workable communications system and to operate "flexibly" under altering conditions to attain common goals.

The individual sessions provide opportunities to trace the development of the self-image from mirror images of adult figures (principally parents) and significant others.

The thinking is that if the couple's mirror images are based on their own parent's neurotic distortions and are derogatory rather than accepting, the child, lacking in experience and judgment, will almost certainly incorporate these images and develop a negative self-image.

In dyadic sessions the impact of the negative self-image on the interpersonal relationship of the couple is pointed out. Interpretations to both partners that this factor is disturbing the couple's relationship can be valuable in improving the quality of their relationship. Furthermore, as both partners begin to understand the ways in which they operate towards one another because of their poor self-images, pressure to change is developed.

The next step involves bringing into focus the positive and creative aspects of the individual partner's contribution. The indications for the combined approach in the treatment of couples include the following:

1. Initial evaluation indicates dyadic sessions to manage the couple's relationship in order to achieve harmony, and individual sessions for entrenched intrapersonal conflicts.

2. Therapeutic "deadlock" with other purist techniques e.g. classic or collaborative techniques.

3. Acting out by one or both partners that cannot be dealt with by other techniques.

4. One partner's personality pattern which makes it necessary to enlist the cooperation of the other.

5. One partner's relationship with a parent (own parents) introjected to such a degree that they are challenged or threatened by individual needs i.e. social, hostile or other dependent needs. Transference issues that block the relationship to such a degree that the therapeutic value of the individual session is lost or disrupted.

The combined technique (simple kind) is a useful therapeutic medium when both individual and dyadic sessions are required, either for the successful treatment of the couple's disharmony, or for one of the partners. Flexibility in using the combined technique in which a therapist may move from one type to another as the situation dictates, is most important.

Finally, Leslie (1964)[33] states: "...most counsellors, most of the time, prefer to do some individual interviewing of the partners early in counselling. At these individual sessions, excessive hostility to the other partner is drained off through catharsis. Privileged communication is permitted. The revelation of attitudes and behaviour that would not otherwise be revealed with the other partner present, is accomplished through diagnostic study of each of the two partners. When the counsellor believes that the couple can work productively in joint sessions, the conjoint therapy becomes the sole or major technique for the counselling process. The joint interviews become the major vehicle for insight development, and further individual interviews are used only when anxiety in one of the partners mounts to the point of interfering with the progress of the joint interviews... experience indicates that some individual interviews mixed with more frequent joint interviews to be the most widely applicable conjoint therapy".

3.5.2 Practical Suggestions for Beginning Treatment using the Psychodynamic Approach and the Combined Technique.

The writer acknowledges that the idea of joint interviews is not always accepted by couples. A careful examination of the reasons for the use of this technique usually brings at least a superficial agreement to try it.

Before the conjoint phase is attempted, the therapist should, in the writer's opinion, engage with each partner in individual treatment sessions. This "individual diagnostic phase" as Greene (1972)[34] notes, "....permits each partner fully to relate their presenting complaints. Being seen individually permits revealing so-called 'family secrets', e.g. infidelity and expressions of feelings in their full flower without fear of retaliation from the other partner". Conjoint sessions are indicated early on in the treatment plan especially when the therapist senses that the "time is right" and/or when it is safe to enter the conjoint phase of therapy.

As the individual sessions give way to the joint sessions and where individual agendas are "contained", the first few conjoint sessions can "give the therapist a great deal" in terms of the type of person the primary client/partner has selected as a mate and from observing the interaction between the couple. In addition, each partner supplements the other's history of events and provides a different dimension to the situation of the "presumably disturbed" person.

More specifically, Sager (1967)[35] suggests that in the first diagnostic interview (joint session) it is often possible to see one or the other partner relate to the therapist as an ally to be used against the other partner. "Sometimes", the author notes,"...the opposite occurs and a

partner sees himself as the protector of his partner against the therapist who is viewed as an antagonist".

Sager notes further that by the end of the first few individual and joint sessions, (number of sessions to be decided by the therapist) the therapist is usually able to obtain substantial knowledge of both partners: individually and in their interrelationship. This includes the knowledge of each individual's symptoms and their psychodynamics: the way each perceives their own and their partners role, function, and place in the general and specific scheme of their relationship. Also the extent to which factors which operate to stabilize the relationship or cause friction.

It is important, according to the author, for the therapist to look for the extent, and, if possible, the source of the anger, hostility and frustration each experiences with the other. Attention should be given to reasons for realistic and neurotic interpretation of each other's behaviour and for the way in which negative feelings are sometimes handled.

The therapist is thus able to gain some knowledge of the way in which their parents related to one another, the relationship of each partner to their parents, siblings, if any, and the way in which each sibling is perceived.

Additional matters in which knowledge is obtained in the early sessions includes the dynamics of the interrelationship between the partners and their reactions to each other, as opposed to their adaptations to other persons. Of great significance are the specific transferences, regressive and adaptational phenomena used by each partner and what these actually arouse in the other partner.

The therapist is able to see the degree to which the partners respect each other and whether they have the ability to give

and receive affection. Some evidence of cultural and socio-economic factors relating to the genetic past and present of both partners is also attainable.

Sager stresses that it is not possible to deal completely with all the issues mentioned here in the "first few sessions", but they can be used to allow for adequate ventilation and interaction. The writer sees this, in itself, as being a catharsis. It is also a method of assimilating the history which is a necessity in terms of the writer's applied framework of client assessment.

After a "satisfactory" history has been taken from both partners, (gained during the initial individual sessions) and the joint diagnostic sessions have passed, the time is appropriate for the therapist to suggest an appropriate treatment programme consistent with the couple's goals. Shifting individual sessions with either partner to conjoint sessions should remain flexible. There, too, should be flexibility of goals in a broad sense, since what happens, in effect, is that regardless of the set goal, most writers note that throughout the conjoint sessions (regardless of the level on which they are conducted, or with what theoretical approach) runs the thread of improving communication between the partners. This has a meaning and significance far beyond the level of language or semantics.

With communications improved, it becomes possible to "work through" those problems which may exist (in part) because of poor communication. In other words, communication is probably the most important single point of focus as both cause and effect in terms of the discord noted in the therapeutic situation.

The author notes the following points for consideration:

(1) First a description of current behaviour between the partners. Attempts should be made to identify and describe the sources of disturbance but with no confrontation other than that which occurs naturally as the clients "discharge" their complaints and feelings. Catharsis on this relatively simple level may bring relief of some pressure and accompanying symptoms.

(2) Secondly, the therapist might attempt to work through the problems relating to the partners role, function, rule setting, issues concerning dominance and "pace setting" of the relationship.

(3) A third consideration consists of pointing out defensive behaviour and the raising of questions regarding the source of the "defensiveness".

(4) Finally, the interaction between the partners and the therapist might be utilized to produce "change" in the relationship. Here reference is made to transference and counter transference factors, utilizing the behaviour of both partners with respect to each other and to the therapist to produce insight.

Association, dreams and non=verbal communication are assessed through the techniques of psychodynamic interpretation and simple physical observation. Emphasis, wherever possible, is to be focused on those approaches which deal with change from within each individual. This is gained through interaction and the development of insight. To utilize the dynamics of the relationship for this purpose, can give great leverage to the therapeutic process.

Sager emphasises further that dreams be brought to the sessions. These can be related by both partners, who may then participate with the therapist in their interpretation.

A dream related by one partner can serve as a dynamic force in bringing into view hidden agendas and attitudes which can affect both partners. These may then be effectively used in the therapeutic process (either in individual or conjoint sessions).

Finally, the author notes that ".... the engagement of the mates in the joint process of treatment often becomes the first cooperative venture in which they have participated in a long time, if ever".

The writer sees the process of the "combined simple technique" as having three individual inputs (therapist included) working on the problem areas of the couple.

There is the belief that people in committed relationships select as partners persons with psychodynamics similar to their own (or equivalent to their own). As such, they might be said to be unusually perceptive in their understanding of their mate's unconscious motivations while unable to see their own.

The close association of the partners, as well as knowledge of each other's life history, family and friends, might speed up the perception and the working-through of the "projective identification" reactions, resistances and conflicts.

The entrance of the therapist into the existing relationship of the partners can bring about changes on both reality and fantasy levels. The therapist can derive from the dynamics of the relationship an insight, that, when reflected back to the couple, can greatly increase the possibility of helping both individuals in problem resolution. Healthy re-integration to a desired level of functioning is thus encouraged.

3.6 The Importance of the Clinical Home Visit

In 1917, Mary Richmond[36] wrote, "In the office, clients are on the defensive and justify their visits by their replies. In the home, the social worker is on the defensive: the host and the hostess are at their ease".

As described earlier, the writer notes that in clinical social work practice, as a result of rapid professionalisation, there has been the move to see clients in the confines of the office or agency. Therapists now see clients almost exclusively in the office setting.

Paterson and Cyr (1960)[37] state that "one of the frequent concomitants of rapid professional growth and development, is the premature abandonment of methods and procedures which in some circumstances still could serve a useful function. Social caseworkers are now in the position of having to witness the enthusiastic adoption by other disciplines of a procedure that they once regarded as almost exclusively their own- the use of a visit to the home of the client as a means to establishing a diagnosis and providing therapy".

The writer notes that it is the traditional heritage of the social worker to make home visits. The home visit remains (perhaps dormantly so) the pioneer method of interviewing and fact-finding in the social work profession. The writer notes with regret Sharon K. Moyniham's comments: "As attitudes have changed within the profession and caseworkers have become adept at using the more office-confined psychoanalytic model of interviewing, the use of the home visit has declined". Moyniham,(1974)[38]. In terms of the psychodynamic approach and the writers' choice of the Combined (simple) technique as a delivery system in the treatment of couples, it is of major importance to the writer to include wherever possible (as and where circumstances allow) in the therapeutic contract, an

agreement that the couple at some stage in the treatment undergo evaluation in their home environment.

The writer sees the home visit as a simple technique which can expand the therapists professional knowledge of the couples system. It also serves as a vital adjunct to the therapeutic alliance, offering the therapist a dimension which is crucial to the assessment and diagnosis of the client(s) discord.

The home visit often affords additional clues and insights into the nature of the relationship. The writer would argue that perhaps this is the only effective method of conducting an examination into the natural environment of the client, i.e. their home.

Moyniham notes further that "caseworkers are equally skilled at using the home visit as an outreach technique with families who would otherwise be emotionally unable to engage in treatment in the office.

The writer notes that the clinical home visit actually communicates to the client(s) that the therapist is willing to risk him/herself on the "clients' terms". The client(s) can return to the office interview with an observable increase in comfort and cooperation in their relationship with the therapist. Also of note, the writer acknowledges that the home visit cannot carry the weight of reducing transference in the psychoanalytic sense. (This still has to be addressed as and when it arises), but it does reduce some of the initial resistance often displayed in the client(s) testing of the therapists interest and willingness to help. This in itself, on a purely physical level, the writer sees as an immediate concrete offer to help. Therefore, the visit must be seen as a positive contribution to the therapeutic process at a time when the couple understandably wants to expect more than any therapist can realistically provide or promise.

The very fact that travel and time are involved implies a willingness and interest from the therapist to extend him/herself.

It also carried the message that the therapist wants to "personalise and individualise the couple" from others who are seen in the therapist's waiting room. Here is a dimension which the writer sees as an intensely personal concern for the welfare of the couple system, and which must be shown as such.

However personal the home visit is intended to be, Bloch (1973)[39] suggests... "it should be noted that at the outset, the visit is a professional event, not a social one. It is important to emphasize that the purpose of the visit is to advance the therapeutic work".

The professional nature of the visit, however, should not be interpreted in terms of excessive formality, nor should therapists allow themselves to be placed in the role of distinguished visitor. Also, the therapist on the home visit should 'not be limited' in terms of their own physical examination of the 'living space' which Bloch sees as an "essential feature of the clinical home visit.

Bloch also notes that the couple should set the tone and pace of the visits (with facilitating suggestions from the therapist). Where applicable, it is necessary for the therapist to indicate quite directly and clearly that the interest in "being with the client" is to undertake a complete physical examination of their 'living space'. This, once again, Bloch stresses as an essential feature of the clinical home visit.

Bloch emphasises that "no places should be permitted to be off limits and the usual restriction of visitors to public areas

does not apply. The intimate areas of the house are related to the therapeutic work in the same way that the intimate areas of the body are routinely examined in a good physical examination, without apology, shame or prurience".

Essential information can be gained by the therapist after such an examination. The diagnostic and therapeutic process can be greatly enhanced by a therapist who is careful to explore and analyse the physical dimensions of the couple's living space.

In sum, the writer sees the importance of the clinical home visit as an integral part of the treatment programme. Whenever, psychodynamic therapy is undertaken as the treatment of choice, the therapist, in the writer's opinion, should always strive to include at least one or two sessions (as part of the therapy and/or assessment) at the client's home. Working to overcome this barrier if the clients resist the suggestion to "do a home visit", should become a short term goal for the clients (couple) to work on. As Bloch states, ... "despite the resistance and the difficulties, the rewards are bountiful for diagnostic understanding and for therapy".

In part one, the writer has attempted to outline some of the main aspects which support the validity for Clinical Social workers working with couples in therapy. Of note is the writer's choice of the psychodynamic approach to couples therapy.

The dovetailing of the psychoanalytic movement with the development of clinical social work as a specialty of general social work, is explored. Both historically and theoretically, a case has been made, not only for clinical social workers working with couples, but also that clinicians need to adopt a particular therapeutic approach to their work.

Reference is made in part one to the major current approaches in couples therapy which are available to therapists, while a brief synopsis of alternative methods to the psychodynamic approach is also highlighted.

Included in part one is a discussion of the principle concepts of the psychodynamic approach in couples therapy. Special emphasis is focussed on an understanding of inter- and intra-personal dynamics when treating discord in dyadic relation-ships. The concept of therapeutic contamination with reference to transference and counter-transference issues is especially noted.

Finally, in part one, the writer discusses an overview of the current techniques used by therapists in couple therapy. Of these a case is made for combining two selected techniques which, in the writer's opinion, best serves the application of psychodynamic approach in the treatment of couples.

In Part two, short-term dynamic psychotherapy is introduced as a strategy of intervention when working with couples in therapy. Essentially time-limited, this economic form of treatment is proposed as a suitable alternative to the more traditional long-term form of therapy with couples. Also in part two, the necessity for scientific evaluation of intervention is discussed.

PART TWO

Chapter 4

4.1 Short Term Dynamic Psychotherapy in Couples Treatment: A Time-Limited Form of Intervention

"Along with pharmacotherapy, short-term psychotherapy has become the dominant form of psychiatric intervention of the past twenty-five years", (Davanloo, 1978)[40].

It may be of interest to the reader to know that Freud at first practised brief treatment when he believed that to know the cause of a neurosis would lead to its resolution.

To give strength to the concept of utilizing short-term therapy as opposed to long-term psychotherapy, the writer wishes to point out that in its early days, psychoanalysis was considered to be brief therapy. Treatment lasted from a few months to about a year (today a full course of classical psychoanalysis may continue for a few years). Goleman (1981)[41] notes "... In his autobiography, conductor Bruno Walter describes a successful sex-session treatment by Freud in 1906. Two years later Freud used a single four-hour session with Gustav Mahler to cure the composers impotence with his wife. Freud did it by giving Mahler insight into the fact that he identified his wife with his mother, an identification that would naturally inhibit his marital relationship".

According to Freud's biographer, Ernest Jones, Mahler was greatly impressed when Freud said to him "... I take it that your mother was called Marie. I should surmise it that you married someone with another name, Alma, since your mother evidently played a dominating part in your life? Thereupon

Mahler told Freud that his wife's full name was Alma Marie, but that he always called her by his mother's name, Marie".

The writer notes that the various forms of brief psychotherapy practised today in most clinical counselling settings, offers a fixed time limit on treatment - not just as an economy measure, but as part of the treatment. Some therapists see brief therapy lasting up to no more than fifteen or twenty sessions. The writer's own specified number of sessions in terms of a psychodynamic approach in short-term couples therapy (using the combined conjoint-concurrent technique) is no longer than six to eight sessions. Provision is made for follow-up sessions should this be necessary.

The writer sees that for the clinical social work therapist (engaged in working with couples, and whose orientations are psychodynamic), brief therapy means offering a streamlined version of psychoanalysis. This type of 'streamlining' has even been called "analytic permutation" by some writers and "short-term dynamic psychotherapy" by others.

As a time-limited format of intervention with couples (and/or individuals), and in keeping with the writers' belief, (Stuart 1980)[42] notes that "... it has been found that short-term treatment often offers greater benefits than treatment of longer duration. It is also possible that most of the benefit that treatment can offer is derived during the first five to ten sessions. Finally, in planning treatment duration, therapists seem to be more guided by their own theoretical commitments than by their clients needs. That is, therapists subscribing to theories that call for long-term treatment tend to see their clients as needing many sessions. Early terminations are most often client-initiated, suggested by the therapist only upon very strong 'resistance' from the client. Conversely, therapists

subscribing to short-term or crisis-orientated treatment, tend to conceptualize clients needs in terms of fewer sessions. In either event, it is the therapists belief rather than the client's distress that may exercise the greatest influence upon early notions of the ideal treatment duration for any given client".

Seen more positively, there is reason to believe that the setting of short-term limits on treatment may help the couple to mobilise their resources quickly and efficiently, with sufficient time to deal with their concerns. It seems to the writer that a time limit may motivate the client/couple to make more appropriate use of the treatment situation. The writer believes that time-limiting treatment lends a sense of immediacy (and sharpness), bringing an urgency to planning. This tends to make structuring the process clearer. The writer sees, too, that there can be less "drifting" in therapy.

For short-term therapy 'to work', the client/couple should display the characteristics that would make them good candidates for psychoanalysis: this includes the capacity for insight, the capacity to form meaningful relationships, and the ability to think in terms of psychological interpretation. Two other additional prerequisites are (1) a well-defined "concern" or issues, and (2) a strong motivation to alter the area of dysfunctioning.

Short-term dynamic psychotherapy can be seen as an effective way of dealing with (and preventing) the couple from becoming over-dependent on the therapist. The issue of termination has a specific psychodynamic use; it puts the issue of separation (from the therapist) squarely at the clients capacity for "autonomous functioning". Dynamically, this may be seen as the client's ability to counter his/her need to see him/herself as helpless, inadequate and in need of

dependent support. The act of terminating may well encourage the client/couple's independence and self confidence, and, in so doing, enhance any growth and development made in therapy.

The writer sees planned short-term treatment actually referring to a "type of structure" for treatment. This type of treatment implies two necessary characteristics: that of providing the client with a termination point, and that of having a specific focus/concern towards which the couple and practitioner agree to work.

Lemon and Goldstein (1978)[43] point out that much of clinical social work falls into the category of short-term casework, the duration of which is planned and agreed on before treatment of the couple begins. An important aspect of short-term dynamic work, is that time limits are set in order to allow the normal business of "process" or "casework" to proceed. Here the understanding is that the therapist and the couple, in some instances, will decide as they progress whether a "longer" period of treatment is both desired and needed.

The writer would like to point out that couples who choose the use of a brief therapeutic relationship are afforded an opportunity to grow. Should the couple choose not to leave the solution of their problems entirely to the therapist, they can become more self-directing and therefore have the potential to become less passive and more "self-determining" in terms of self-responsibility.

Selection Criteria and Evaluation for Suitability for Short-Term Dynamic Psychotherapy

Planned, time-limited dynamic therapy, is appropriate for adults or couples whose emotional and psychological egos can

adapt to the stress evoked in therapy. It is not recommended for clients who at the time they apply for help are in an acute state of emotional trauma. In these cases a more flexible form of treatment, other than short-term stress-evoking therapy, is required.

(1) Couples must be able to keep weekly appointments regularly.
(2) Those suffering from serious "mental disturbance" are not suitable.
(3) Because the strict adherence to a predetermined schedule usually evokes a high level of stress, it is not appropriate for clients prone to destructive acting-out, or violent behaviour, to undergo this type of therapy.

In essence, the writer sees the therapist making the choice, after evaluation of the couple, whether to engage the couple in a course of brief treatment or not. This is dependent on the social workers understanding of the way in which the couple's underlying fears and anxieties influence their day to day lives. The therapeutic relationship in the main, means to make a careful assessment of the couple's ability/-capacity to undergo short-term psychodynamic treatment.

Using a particular model of short-term dynamic therapy, Greenspan and Mannino(1974)[44] suggest that a short-term treatment approach using the earlier-mentioned Kleinian form of analysis, namely "Projective Identification" with kinds of couples described in points 1 - 3 above, may be the treatment of choice in helping certain couples to correct perceptual distortions involved in projective identification.Their model is intended for short-term intervention (time-limited) and this is in keeping with the writer's emphasis on inter and intrapersonal dynamics when treating discord in dyadic relationships.

Davanloo (1978)[45] discusses the use of a "broad-focussed (short-term) time-limited, dynamic psychotherapy". This is the treatment based on "special focus interviews" for clients. Exploration of the genetic material, with techniques of confrontation, clarification and exploration into conscious, preconscious and unconscious material is the main thrust of therapy.

The major task of the therapist is to understand as quickly as possible the essential problems presented by the couple. The therapist then endeavours to explain the complexity of the client's problems to the client in a more cogent manner. The therapist is much more active than in classical psychoanalysis for, according to the author, "... there is no place for a passive therapist in this kind of treatment". Attention is given to the present manifestation of the consequences of the couple's presenting problem(s).

The clinical social worker, in order to fulfil his/her function as a psychotherapist, must have the clinical skill, ability and flexibility to choose the psychotherapeutic method which will most effectively alter the couple's dysfunctional pattern. In short-term dynamic work, the essential theme is that the clients perception should be that it is themselves who must alter in some way and not the outside world.

A pre-therapy screening of clients who severely project in this manner might be indicated. The reason for this is that in short-term work there is not time to begin character reorganisation of those clients. This is reinforced by the notion that in short-term therapy, supportive techniques, emphasising the clients strengths, weaknesses and self-responsibilities to alter or accommodate certain issues, is desired.

The personality of the evaluator, his/her style and technique, influences, to a great extent, the evaluation of clients for short-term therapy. This, in turn, influences the type of couple being selected, and the psychotherapeutic technique used. These issues do affect the therapeutic outcome in one way or another.

The suitability of a client/couple for dynamic short-term psychotherapy requires, in the final analysis, a clinical analysis that is not based simply on a clinical diagnosis. The clinical social worker, with specific skills and understanding human interaction, brings to the therapy interpretations made of the central dynamic structure of the couple's presenting problems. Davanlóo states "it is essential that every clinician develop to a sufficient degree the clinical diagnostic skills to understand and describe his patient in the light of his developmental history, the genetics of his disturbances, his intrapsychic conflicts, the strength of his id and his ego forces, his character structure, and his adaptation to and interaction with his environment". The clinicians ability to think in this manner is central to sound planning and therapeutic evaluation in short-term dynamic work.

The following criteria are recommended for a clinical diagnosis. The writer sees this process as being the essential task of the therapist in short-term therapy:

(1) Establishing a clinical picture (diagnosis).
(2) The determination of a genetic diagnosis (family-of-origin history).
(3) Establishing a current dynamic diagnosis/evaluation.
(4) Choice of alternative psychotherapeutic techniques-possibilities (short-term dynamic treatment in terms of technique).

(5) Evaluation of transference and countertransference issues.
(6) Formulation of short-term treatment goals with the couple.

By way of summary, an attempt is made to bridge the gap which exists between the classical teachings of psychoanalysis, and the contemporary Neo-Freudian psychodynamic approach as practised today. More specifically, the gap was perceived as that of the client only really being helped by full analysis lasting years on the one hand, and on the other, the more modern view that the client can be treated by short-term psychodynamically oriented methods of practice. This latter consideration is currently widely and accepted by most psychodynamically-oriented practitioners today.

Mann (1978)[46] writes, "The topic, short-term dynamic psychotherapy, is by no means a neonate or even a fledgeling. It is already a youngster, brimming with enthusiasm, a youngster already recognised as showing strength and inventiveness, and promising great hopes for the future".

The clinical social worker could make use of this form of time-limited psychotherapy. It is seen as an economically viable alternative to reaching and working with couples, who are good candidates for the psychodynamic approach. The writer sees this approach as dovetailing with the combined conjoint-concurrent techniques described in the previous chapter.

Finally, the therapist must be aware of some of the dangers that need to be foreseen when working with clients/couples in dynamic therapy. Malan (1978)[47] notes five important concerns: (a) the prediction that issues will become too complex and deep-seated to be resolved in a short time, (b) severe dependence and other forms of unfavourable

transference, (c) the danger of decompensation into a psychotic episode, (d) suicide or "family/other pacts" or (e) uncontrollable acting-out. Ultimately the therapist must believe that the client/couple have the strength to manage on their own, both in between sessions and after termination of therapy.

Limitations of Short-term Psychodynamic Couples Therapy

The writer wishes to acknowledge that the kind of therapy proposed in this dissertation is by no means the only method of working with couples who are experiencing difficulty in their relationship. There are several shortcomings to this approach which need to be pointed out.

Firstly, the selection criteria for potential client couples, is fairly specific and is limited to a certain "type of client/couple". By this the writer makes reference to the selection criteria mentioned in Chapter Four, page 66. As the selection criteria for this type of treatment is narrowly defined, the reader might argue the the selection process is too stringent, that it is extremely limiting by way of client selection, and that a large percentage of couples who do not possess the criteria for selection could not benefit from this approach.

Secondly, the reader might query the strict adherence to a time limited set of ten to twelve sessions proposed by the writer. Mental health professionals might challenge this particular form of treatment on the basis that it is too short a time to effect any meaningful change in the couple's system of functioning.

Thirdly , the criticism most frequently levelled at this approach is that it pays attention only to current symptomatic discord. There is little or no attention given to structural change in

terms of the clients' deeper-rooted pathology (within the couple's dysfunctioning system).

A fourth criticism is that the whole approach to short term dynamic therapy is seen as a "streamline" psychoanalytic attempt, which by its very nature cannot achieve the goals that the more traditional long-term approach can achieve.

Often criticism aimed at short-term approaches includes issues related to the "economics" of therapy. The feeling in some quarters is that this approach merely "fits in" with the economics of a particular agency. There is a statistical concern for high client turnover rates in some agencies. It is well known that some agencies depend on financial aid which is determined by case-load numbers. The writer sees the possible use of this approach as a means to increase agency subsidy.

Finally, there are those who criticise clinical social workers for becoming involved in the therapeutic management of "healthy and functioning people from wealthy backgrounds". The argument here is that such practitioners ought to be working in the more traditional roles where their clinical skills might be of more value.

The writer does not believe that the approach proposed is by any means the only manner of dealing with couples who seek help. However the criticisms mentioned here are valid and need to be answered. A therapeutic approach which is more economical and which reaches more of the client population is perhaps the ideal short-term intervention procedure.

Chapter 5

5.1 Short-Term, Conjoint-Concurrent Dynamic Couples Therapy: The Necessity for the Scientific Evaluation of Intervention

As pointed out in the previous chapter, short-term dynamic therapy has been practised for some twenty five years and is hardly new as a treatment approach.

In spite of this the writer acknowledges that there are few systematic, large-scale studies to date of the effectiveness of such treatment with couples in the field of clinical social work.

Methodological problems in evaluating the success of treatment, offers the evaluator a great deal of philosophical difficulty which, in turn, influences the outcome of evaluating treatment.

Also, lack of agreement on the criteria of success, the timing of evaluation, and the establishment of controls as a base for what may be termed "scientific measurement", presents the evaluator with additional problems.

Among the criteria used are: disappearance of symptoms; overall improvement in adjustment; less socially-disruptive behaviour; greater family cohesion and, in some cases, improved scores in psychological tests. Parad (1970)[48] notes that "The dilemma might be dichotomised as: Is the patient 'feeling better' or 'functioning better'?". Questions like these are constantly being raised concerning reliability and validity. Also, should evaluations of outcome be made by the client/couple, therapist or significant others?

Writers have suggested using some of the methods used in evaluating medical disorders. These include comprehensive baseline studies at the beginning of therapy as well as the recording of specific data to provide a means for comparison at the conclusion of treatment. (One such method will be discussed in more detail later in this chapter).

Problems in timing include: whether effectiveness should be rated at the time of client termination, or at follow-up. If at follow-up, what are the optimal intervals for spacing such as follow-up assessment/evaluation contracts?

There is also the problem of control groups. If one is doing a comparative study, with which group should the study population be compared in order to assess progress? Trying to establish a control group can prove to be very difficult, as it usually offends people's principles.

The possibility of a subjective effect on the assessment of an outcome by a therapist whose philosophy has always been based on long-term traditional work, must also be taken into consideration. Attention is to be focused on certain research efforts which have been directed towards these problems.

Some of the research enquiries have challenged mental health professionals with the necessity of developing criterion measures, which would assess the effect of variables in the therapeutic situation. By 1954 Rogers[49] had already pointed out that "effectiveness of the subjective estimates of the so-called overall effectiveness of treatment, implies a value judgement which is not appropriate to scientific enquiry". (The writer interprets this as the therapist giving opinion of treatment progress to date).

Klier (1981)[50] discusses the need to examine the process of planned short-term dynamic treatment, rather than simply focusing on the outcome of the therapy. To evaluate the process of short-term treatment, Klier devised a system in which the therapist recorded both treatment goals and the stipulated length of therapy. Clients and therapists completed questionnaires on the attainment of these goals after the last session of treatment. Three months later, both therapists and clients completed questionnaires that enquired about the client's experience in follow-up treatment as well as the situation regarding the original treatment goals.

In terms of the outcome Klier found that clients and therapists reported high achievement in reaching agreed-on goals in most cases, both when initially questioned, and at termination and follow-up. This type of before-and-after study may seem to be the only true method of evaluating short-term dynamic therapy. Yet the author asks the following important questions: "Should working goals be extremely specific or broader? Is one duration of treatment more effective than another? and; How brief is short-term treatment?"

These questions are highly individualised issues. They are to be discussed with the couple during the contracting phase of therapy. Once clarity is achieved, the interpretation of these matters must form a part of the working contract. Also, the contract must also be adhered to as a matter of professional requirement throughout the treatment.

Segraves (1978)[51] describes a theoretical framework for dynamic brief conjoint couple's therapy that is "both dynamically relevant and capable of empirical testing". Segraves discusses several hypotheses which can be subjected to scientific validation.

Segraves hypothesised that in cases of couples discord one or both partners have "perceptions" of the other person that are markedly different to that person's personality.

Clinically, this could be seen as a misperception of the partner's character. Segraves notes that this hypothesis "clearly leads to the prediction that couples in distress will misperceive one another's character more so, than couples who are happily married".

Dymond (1978)[52] reports that "happily married couples have more accurate predictions than unhappily married couples, of each other's self reports on the Minnesota Multiphasic Personality Inventory List". In this way the author offers scientific support for this hypothesis.

Dymond also hypothesised that misperceptions are learned from previous experiences with the opposite sex. In cases of couples discord, Dymond believes that "there has been a failure of discrimination in terms of dynamic development, in one or both of the partners. The person has difficulty in observing differences in the external reality of the present partner and the internal images of the opposite sex as gained over time".

Further, Dymond recognises that the above hypotheses can be tested by "comparing the similarity of description of partners, opposite sex parents, other significant members of the opposite sex and the opposite sex in general, in groups of happily and unhappily married couples". Dymond predicts that the distorted images of the opposite sex will be more negative in the unhappily married group, also that unhappily married people perceive their spouses more negatively than happily married people.

These distorted perceptions contribute to interactional sequences that maintain these distortions. This has been discussed in Chapter 3 (3,2) where the Kleinian approach to intra and interpersonal concepts is discussed; i.e. projective identification and "collusion":- (intrapsychic mechanism whereby unacceptable unconscious feelings are projected onto one's partner).

The writer sees the value and importance for therapists to be able to evolve a model for brief "combined" dynamic therapy (for couples) that attempts to satisfy the following three important conditions noted by Dymond:

(1) that the therapy is capable of being empirically tested
(2) that it relates individual psychopathology to interactional difficulties, and
(3) that it be clinically relevant.

In sum the writer realises that measurement of short-term psychotherapeutic outcomes ought to be expressed in specific terms. This should become standard practice when one is working with a short-term approach in couples work. No longer will it "do" to simply judge the couple as having generally "improved". Appropriate scientific evidence is needed to convince our colleagues and other clinicians as to why one technique or approach is preferable to another.

In any therapy study criteria must be defined. If the therapist decides that "dynamic change" is what is desired it must be documented in such a way that it is scientifically reasonable and that change has occurred.

If the clinician is looking at a couple's "feeling state", the therapist must make certain that they measure it in a meaningful way. If outward behavioural change is desired the practitioner must be able to specify what kinds of behavioural changes will be accepted as evidence for the

efficiency of the intervention.

The days of mixing criteria are passed. Agreement on the value to be placed on the changes which therapy identifies is needed by client and therapist in advance. In addition, therapists ought to strive for a kind of "specificity" that is perhaps lacking in our current therapeutic work in respect of evaluation of short-term couples therapy.

The time has come when practitioners have to provide scientific evidence in favour of the therapeutic process or face the notion of not having value in the therapeutic market place.

Psychotherapy will always have its critics since the public at large remains unconvinced of its scientific value in terms of its scientific feasibility. Society demands an explanation by way of scientific proof. The only real avenue is to continue to spell out the conditions and circumstances under which particular techniques will achieve particular results.

Clinical social workers should periodically evaluate their practice so as to further enhance scientific knowledge. This refers to therapeutic approaches and techniques that they choose to use in their daily practice.

In closing, Nadelson et al, (1975)[53] point out that "the primary focus of the evaluation procedure for a couple should be on the interaction between the partners. In order to understand the multiple ways in which partners affect one another, both ought to be evaluated individually. It is necessary to clarify individual roles and views in the relationship, as well as the personality dynamics, which contribute to the problems presented. The evaluator cannot underestimate the importance of the individual styles of

adaptation, use of defences and resistance, tolerance of stress and ego strengths, and the capacity of each person to be supportive and empathetic to their partner. All of these factors, together with motivation for treatment, are components in formulating therapeutic plans. The model of treatment that takes these issues into account should be eclectic and flexible".

Conclusions

This dissertation has attempted to address the need for Clinical Social work practice with couples. Recognition of this specialisation in social work practice and the social work practitioners therapeutic services in this regard, is the theme of this paper.

The social work clinician has the right to work with couples in this manner. The historical roots discussed in Chapter One, point clearly to the "marriage" between social work and psychotherapeutic practice. This, too, is borne out by Baird in Lieberman (1982)[54], in her chapter on social work contributions to psychotherapy. The person-in-the-situation, self determination, nuturing, the family system, stress of deprivation and separation issues; these are some of the contributions "clinical" social work has given to current psychotherapeutic practice.

The initial hurdle lies in convincing the therapeutic community of the efficacy of clinical social work practice. This the writer discusses in Chapter One. The development in the United States of a working definition of Clinical Social Work does much to convince the reader of the 'place' of social work in therapeutic services.

In Chapter Two the similarities between marital therapy and couple therapy are highlighted. The writer defines for the purpose of this dissertation, couple therapy as being "two people regardless of their sex, who are engaged in a committed relationship and who have entered into a therapeutic relationship with the clinical social work practitioner".

The reader is offered an overview of some of the main therapeutic intervention approaches and the therapeutic targets which are available to therapists. Five of these are briefly discussed and their frameworks are highlighted. What emerges in Chapter Two is that the growth-orientated approaches and the problem-solving approaches can be seen to belong to "two camps". The problem-solving approaches do not fall within the scope of this dissertation. As such, limited attention is paid to this alternative school of thought and practise. Of the growth-orientated approaches mentioned in the text, the writer chooses to focus almost exclusively on the psychodynamic and transgenerational approach.

The principal concepts of the psychodynamic treatment model in couples therapy are discussed in Chapter Three. Inter- and intrapersonal phenomena, family-of-origin issues and transference and countertransference are discussed. The influence of these factors on the psychodynamics of the client system in treatment, is highlighted.

Diagnosis of problematic functioning with clients who are in a committed relationship, can be clouded by transference and countertransference. The writer stresses the importance of this especially when the psychodynamic framework is in use. The danger of treatment contamination by these issues is emphasised as a matter needing careful attention if treatment is to be of optimal value.

The therapeutic use of the helping relationship by the therapist is a consideration which can foster closeness in the couple's relationship. This the therapist may need to develop in order to facilitate the working relationship with the clients.

Psychodynamic short-term therapy in respect of couples work, can only effectively be applied if done so through the medium of an accepted approach. The writer chose to highlight the various

techniques available and has focused on a combination of the concurrent-conjoint method.

A fairly in-depth account of the indications and contra-indications for the use of the various techniques in therapy is made. The writer's personal choice is substantiated by means of carefully-chosen therapeutic elements and action inherent in the concurrent-conjoint method.

The writer suggests a practical programme for beginning treatment. This includes variations of individual assessment sessions, coupled with conjoint working sessions - the former giving way to the latter.

Chapter Three concludes with an acknowledgement of the important traditional role of the social work practitioner: that of making home visits. The value and importance of making a home visit to the couples place of dwelling is pointed out in the working contract, especially during the assessment phase. The diagnostic and evaluative dimensions of a home visit cannot be over-emphasised by the writer.

In Chapter Four the psychodynamic approach and the chosen technique of therapeutic delivery is placed in a framework which is essentially time-limited: that of a short-term form of intervention. The writer's recommendation is no longer than ten sessions of treatment. This includes assessment and treatment. Provision is then made for follow-up sessions should this be necessary.

Reference to the limitations of the short-term psychodynamic approach to couples therapy is also made in this chapter. These include the strict selection criteria for potential client couples made by therapists and the adherance to a time limited amount of sessions. Also that attention is focussed on the symptomatic issues and not the causative aspects of the discord.

Another criticism is that there is an attempt to streamline the traditional psychoanalytical approach which, by its nature, is long-term. Finally, there are those who would argue that clinicians are working with essentially healthy, functioning people from wealthy backgrounds.

In Chapter Five, the necessity for scientific evaluation of intervention treatment is stressed. This is no different with short-term dynamic couple therapy.

Also in this chapter, two procedures for evaluating such intervention are discussed. The value of the "misperception, projective identification test", which examines perceptual distortion of one's partner's character, and the questionnaire survey design which assess the client's responses at the beginning of treatment, at termination and agein at follow up, are noted as possible means of assessment when attempting to evaluate intervention procedures.

The writer points to both these methods having been developed where verbal feedback from clients was the only yardstick of any therapeutic success.

Recommendations for the Validity of using this Approach in Clinical Practice

In this dissertation, the writer has attempted to put forward the use of the psychodynamic approach to short term couples therapy. A case has been made for the use of the conjoint-concurrent technique as a most "fitting" vehicle for this approach.

The "theme" of this dissertation has been to try and point out to the reader that the validity of short-term dynamic treatment objectives lies in the form and structure of the approach preferred by the writer.

This form of treatment is seen as (a) structured, (b) dynamic, (c) Goal orientated, (d) aimed at symptom reduction, (e) enhancement of intra-personal insight and inter-personal communication, (f) interpretive, (g) economic, (h) adaptive, (i) flexible, (j) practical and (k) is based on well accepted theoretical principles.

As proposed, the psychodynamically oriented clinician is offered an opportunity to adapt treatment to the couple's needs.

Should the clinician wish to evaluate his/her therapeutic programme, the model proposed and the accompanying technique is open to scientific evaluation for functional validity.

The writer sees that this kind of therapy is suitable for couples who are currently experiencing disharmony in their relationship, where the dysfunction is of an acute nature - in terms of recent onset and in cases of persons with essentially healthy personalities.

In essence, the aim of psychodynamic short-term couples therapy is to provide the couple with supportive intervention and some exploration of their fantasies and or needs. This takes place through the medium of conjoint and concurrent therapeutic sessions.

Issues of current interpersonal, family and intrapsychic conflicts are addressed. The main problems are clarified, together with the couple's characteristic defences and methods of problem solving. Transference and counter transference issues are dealt with when and if they arise.

The couple agree to work with the therapist by means of a contract. The requirements of such a contract are that the above issues are examined within a congenial atmosphere.

The couple must possess the intent to seek an understanding of the issues underlying their current dysfunctioning.

Finally, the writer feels the choice of altering any behavioural dysfunction as experienced by the couple rests with the couple and their perception of their own future together.

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